KERRY STUTZMAN, MSW, LMFT
Marriage and Family Therapist
3600 S. YOSEMITE STREET SUITE 1050 DENVER, COLORADO 80237

CLIENT INFORMATION

Name____ DOB____________________

Child's Name (if client)_________________________________ DOB____________________

Address____

Phone Numbers (H)__________________ (C)__________________ (W)__________________

Please circle the phone # where messages can be left.

E-mail_____________________________ OK to send general email messages? Yes No

How did you find me? ____

May I acknowledge the person doing the referring? Yes No

If yes, please enter name of referring person/agency______________________________________

Employer____________________________________ Occupation_________________________

Religious affiliation____

Level of involvement: High Medium Low

Relationship Status: Single Married Separated Divorced Widowed Coupled

Name of spouse or partner________________________________ Phone__________________

Immediate family members (who live with you):

Name	Age	Relationship

Have you ever consulted a therapist or parent coach before? Yes No

If yes, when? ______________________________ For how long?______________________________

Briefly state the reasons you sought counseling in the past. ______________________________

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Do you think that, either now or in the past you have had an addiction to anything? Yes No

If yes, what?____

Have you ever seriously considered or attempted suicide? Yes No

If yes, when?____

Are you now taking any medications? Yes No

If yes, please list medications, dosages, and for what problem.

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Please describe any current or past experiences with abuse (physical, emotional, sexual).

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____

Any major medical issues affecting your current mental health? Yes No

If yes, please describe.____

Your Physician's Name______________________________ Phone____________________________

Briefly describe why you are seeking counseling now. ________________________________

____

____

In Case of Emergency Contact ______________________________ Phone________________

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SERVICE AGREEMENT AND FEE POLICY

Appointments
Your appointment is reserved for you, and I will make every effort to start and end your appointment on time. Since I am unable to fill a canceled or missed appointment on short notice, it is important to notify me at least 24 hours in advance if you must cancel or reschedule. The charge for an appointment canceled with less than 24 hours notice is full fee, and a full fee will be charged for any session missed without notification. Emergency situations such as bad weather, illness, etc. will be considered, but please discuss it with me to avoid changes.

Fees
$140 per 50 minute-hour for parent coaching or individual, couple or family therapy.
Any phone call over 10 minutes will be charged pro-rata.
$75 per page for report writing. $75 per hour for drive time.
$175 per hour for court appearances, including travel expenses, lodging and meal reimbursement.

Fee Schedule
A fee will be charged for all other auxiliary services including progress reports, collateral contacts, or any other report or services made at the request of the client. Fees for auxiliary services will be agreed upon prior to commencement of such services.

Payment Policy
Payment is due in full at the completion of each session or any auxiliary service.
The client is responsible for any insurance claims and/or reimbursement.

Office Hours
Office hours are by appointment only. Availability of dates and times for appointments will be discussed with each client.
Voicemail is available 24-hours a day.

Emergencies
I am not available on a 24-hour basis. I do not carry a pager. However, I do have voicemail, which can be accessed 24 hours a day. I will return your call at my earliest convenience, usually within one business day. Clients seen in outpatient psychotherapy or parenting consultation are assumed to be responsible for their day-to-day functioning. In the event of a true emergency, notify 911 immediately, and then notify me.

I have read, understand, and agree to the above information and services agreement and have received a copy.
Your signature does not bind you to therapy or consultation; however, it does make you responsible for the charges incurred.

____ ____________________
Client Signature Date

Kerry Stutzman, MSW, LMFT
Marriage and Family Therapist
3600 S. Yosemite Street Suite 1050 Denver, Colorado 80237

DISCLOSURE STATEMENT

1. INFORMATION
Kerry Stutzman, LMFT
3600 S. Yosemite St. #1050
Denver, CO 80237
303-770-4667

2. CREDENTIALS
Licensure: Registered Psychotherapist
an unlicensed therapist, you must state: a registered psychotherapist
Degrees: BA, MSW, LMFT
Professional Experience: Private psychotherapy practice, Parenting Instructor, Co-Founder of Seeking Common Ground.
Certifications: Certificate in Marriage & Family Therapy, Certified Love & Logic Instructor

3. REGULATION OF PSYCHOTHERAPISTS
The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION
   a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.
   b. You can seek a second opinion from another therapist or terminate therapy at any time.
   c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.
   d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.
   e. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

5. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

____

Client Printed Name

____ ________________________

Client Signature or Responsible Party Date

If signed by the Responsible Party, identify that party's legal authority to consent to treatment:

____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

View the Notice of Privacy Practices

Name____ Date ________________

By signing this form, you acknowledge that this office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

By my signature below I acknowledge that I have received a copy of this office's PRIVACY NOTICE regarding confidential health information, and have been given an opportunity to discuss my concerns and questions.

____ ______________________

Signature of Client or Legal Representative Date

Therapist complete below if Acknowledgement of Receipt of Privacy Notice form is not signed.

1. Does the client have a copy of the Privacy Notice? Yes No

2. Please explain why the client (or his / her legal representative) was unable to sign an acknowledgement form and the therapist's efforts in trying to obtain the client's signature:

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____ ______________________

Signature of Therapist Date