PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Disclosure and Informed Consent

Service Provider:
Neal Brugman, Psy.D. – Licensed Clinical Psychologist, Colorado license #3786

Education/Degrees:
Doctor of Psychology – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2011
Master of Arts – Clinical Psychology
University of Denver, Graduate School of Professional Psychology, 2008
Bachelor of Arts – English Literature
University of Dallas, 2002

Division of Registrations:
The Colorado Mental Health Licensing Section of the Division of Registrations has the general responsibility of regulating the practice psychotherapy. As to the regulatory requirements applicable to mental health professionals:

A Licensed Psychologist must hold a doctorate degree in psychology and have 1500 hours of post-doctoral supervision (Please note this is Dr. Brugman's level of training). 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 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 Social Worker must hold a masters degree in social work. 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 bachelor's 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 registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

Contact Information
The Board of Psychology Examiners
1560 Broadway, Suite 1350
Denver, Colorado 80202
303-894-7800

Client Rights and Important Information:
As a client seeking mental health services, you have certain rights. These include your right to seek a second opinion from another therapist or your right to terminate this therapy at any time. You are also entitled to receive information regarding the methods of therapy, techniques used, the duration of therapy (if known), and the fees. Please ask if you would like to receive this information.

In a professional relationship (such as ours) sexual intimacy between a therapist and client is never appropriate. Any circumstances of sexual intimacy within a therapeutic relationship should be reported to the Board of Psychology Examiners listed above.

Generally speaking, the information provided by and to a client during therapy sessions is

legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed addiction counselor, or an registered psychotherapist. If the information is confidential, the therapist may not disclose the information without the client's consent. There are exceptions to the general rule of legal confidentiality, which are listed in the Colorado Statutes (C.R.S. 12-43-218). Examples of such exceptions include but are not limited to a client who is an imminent danger to self or others and report or evidence of child abuse or neglect. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. I will identify any exceptions to you if any such exceptions arise while the therapeutic relationship exists or after we have terminated the therapeutic relationship.

The standards of the profession dictate that clinical documentation of therapy must be maintained. If you have any questions or would like additional information, please feel free to ask.

Consent for Treatment (check one)

☐ I _____ voluntarily consent to mental health and/or consultative services with Neal Brugman, Psy.D.

☐ I _____ voluntarily consent to mental health and/or consultative services for my minor child, _____ with Neal Brugman, Psy.D.

Financial Agreement

Standard Service Fees:
Please review the rates for the following services. The rates listed below are based on a 45-50 minute clinical hour. Therapeutic sessions lasting over 50-minutes in length may be subject to additional service fees.

- Individual Therapy: $150 (50 minute session)
- Group therapy: $65 (90 minute session)
- Phone consults (over 10 minutes in length): $150/ hour
- After-Hours Consultations (in person/by phone): $175/hour

Forms of Payment & Policies:
Dr. Brugman accepts all major credit, debit, and HSA cards. Dr. Brugman requires that clients have a credit/debit card on file with him in order to engage in treatment. Cash and check are also acceptable forms of payment; however, a credit card must be on file with Dr. Brugman to engage in treatment. Clients will be responsible for payment at the time services are rendered. If an alternative form of payment is not provided in session, the client's credit card on file will be charged.

Insurance:
Dr. Brugman only bills directly to the following insurance companies: Rocky Mountain Health Plans, Multiplan/PCHS, Mines and Associates, Optum/United Behavioral, American Behavioral, and Medicare. If you would like to utilize your insurance benefits for any other plan not listed above, clients will need to pay the full fee for sessions directly to Dr. Brugman who will then provide insurance-ready statements which can then be submitted

to insurance for out-of-network reimbursement. Please note that out-of-network reimbursement is generally subject to a separate deductible - clients are encouraged to call their insurance company to inquire about these benefits.

Cancellation Policy:
In the event you need to cancel an appointment, please notify Dr. Brugman at least 24 hours (1 day) in advance. If less notice is given, this will be regarded as a late cancellation and will incur a $45 fee. If a client gives no notice of cancellation and does not attend an appointment, this will be considered a no-show and will incur a $90 fee. Please note that these fees are not covered by insurance - clients are responsible for full payment of any late cancellation or no show fees.

Inclement Weather Policy Cancellation Policy:
If Denver Public Schools cancels classes due to weather, Dr. Brugman will waive late cancellation fees for that day. In these instances, Dr. Brugman will assume you are attending unless he receives notice from you before your session - clients who do not give notice of missing an appointment ("no show") will be charged the no-show fee regardless of weather conditions.

Please initial here indicating that you have read and understand the cancellation policy: ___

Phone, Email, and Teletherapy Policies:
The first 10 minutes of time spent corresponding between regular sessions is included with a client's psychotherapy fee. Between-session contacts longer than 10 minutes will incur a prorated fee. Teletherapy or phone sessions are scheduled in the same way that a regular in-person session would be and the fee is the same.

Short emails regarding scheduling will not incur a fee, but if you would like your therapist to read a longer email and respond as they would in a therapy session then charges will based on the time spent to do so. Please feel free to talk to your therapist more about these policies if you have any questions.

Psychological Assessments:
Unless otherwise arranged, psychological assessments are billed at $125 per hour. Prior to beginning an assessment an estimate of the total number of hours needed to complete the assessment will be provided. Psychological assessments are billed on an ongoing basis.

If a report, letter or consultation with an outside party is requested, you will be billed for any time needed to prepare documentation, or to conduct and in-person or phone consultation.

Policy for Non-Payment:
In the event billing efforts fail, delinquent accounts may be subject to collections. This practice will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

Neal Brugman, PsyD
2100 South Corona Street
Denver, CO 80210

drnealbrugman@gmail.com
720.295.7605

Legal Involvement - Policies and Fees
If you become involved in legal proceedings that require my participation, you will be billed for my professional time, including preparation and transportation time costs, even if I am called to testify by another party. Because of the complexity and liability of legal involvement, I charge $250 per hour for preparation for and participation in any legal proceedings.

If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without either your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If you are in a divorce or custody litigation, or involved in the court system in any other manner, my role as your therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and a client. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

Additional Information

Dr. Brugman routinely consults with other professionals in the field regarding ongoing therapy and assessment cases. Privacy and Confidentiality are always maintained in these consultations.

Required Signatures

I understand and agree to the preceding Disclosure Statement, Consent for Treatment, Financial Agreement and the Addition Information provided above.

_____ _____
Signature of Client or Legal Guardian **Date**

Neal Brugman, PsyD
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Denver, CO 80210

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Client Information Form

General Information:

Name: _____ Date of Birth: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Primary Phone: _____

Is it ok to leave private/confidential messages at this number? Yes No

Would you like text message reminders for appointments? Yes No

Email address: _____

How did you hear about my practice?

Name: _____ May I contact this person to thank them? Yes No

Medical Information:

Primary Care Physician (PCP) name: _____

Current medical conditions: _____

Current medications (list all):_____

Date of last physical examination/PCP visit: _____

Past Mental Health Treatment:

Name of Therapist: _____

Dates of Treatment: _____

Reason for Treatment: _____

Have you ever been hospitalized for a psychiatric reason? Yes No

Have you ever made a suicide attempt? Yes No

Psychiatric medications (past/current): _____

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Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Circle one	*List family member(s)*
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Physical Violence	Yes / No	
Domestic Violence	Yes / No	
Schizophrenia/Psychosis	Yes / No	
Suicide Attempt	Yes / No	
Other Mental Illness: _____	Yes / No	

Alcohol/Drug Use:

Do you drink alcohol? Yes No

If so, how many days per week do you drink? _____

How many drinks per day (on average)? _____

Do you use any drugs recreationally (including prescription medications)? Yes No

If so, which drugs? _____ How often? _____

Have you ever been treated for substance problems? Yes No

If so, what treatment (i.e. AA/NA, court mandated, rehab)?

_____

Emergency Contact Information:

Name: _____ Relationship to Client: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone: _____ email: _____

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Billing Information

Preferred Method of Payment:

☐ Check ☐ Cash ☐ Credit/Debit/HSA Card

Payment will be made by your preferred method (cash, check, charge); however, a Credit or Debit Card is kept on file in the event that you do not bring another form of payment at time of service.

Billing Address:

☐ *Check if same as address on 'Client Information' page*

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance:

Do you have health insurance? Yes No

Health Insurance Provider: _____

Do you plan to seek reimbursement from your insurance for our sessions?*

Yes No Unsure

**Please note: I only directly with certain insurance carriers. Please discuss this with me if you would like to obtain reimbursement from your insurance company for our work together.*

I certify the information provided is accurate to the best of my knowledge. I understand that fees are due at the time of service. I authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

_____ _____

Signature of Client or Legal Guardian **Date**

Credit Card Information:

Account Holder Name: _____

Card Type: Visa MasterCard Discover Amex

Card Number: _____

Expiration Date: _____ CVV (3 digit code on back of card): _____

(Please note: once entered into my secure system, your credit card information will be shredded to ensure security)

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