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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7

Over the <u>last 2 weeks</u>, 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*____ = ____ + ____ + ____)

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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 Psychologist 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

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. 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. The client's credit card on file will be charged unless an alternative form of payment is offered at time of service.

Insurance:
Dr. Brugman only bills directly to the following insurance companies: Rocky Mountain Health Plans 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 in advance. If less than 24 hours of notice is given, this will be regarded as a late cancellation and will incur a charge equal to half of the established session fee. If a client does not give notice of cancellation before a session begins, this will be considered a no-show and the full session fee will be charged. For Medicare and RMHP clients, there will be a $45 late cancellation fee and a $90 no show 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 inclement 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.

Letters and Reports:
If a report, letter or consultation for the client or 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.

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.

Surprise/Balance Billing Disclosure:
Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?
If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.
When you CANNOT be balance-billed:
Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider
The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider. You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website:
https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.
Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Retention of Records:
Any person who alleges that a mental professional has violated the licensing laws related to

the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

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
2100 South Corona Street
Denver, CO 80210
drnealbrugman@gmail.com
720.295.7605

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): ______________________________

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

drnealbrugman@gmail.com
720.295.7605

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.).

Mental Health Issue	*Select 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/Substance 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 cannabis? Yes No

If so, how many days per week? ____________

How much (on average) do you consume in a typical week? ____________

Do you use any other drugs recreationally? Yes No

If so, which drugs and 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: ________________

City/State:_______________________

Phone: ______________________ email: _____________________________

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: Dr Brugman is only paneled with Medicare and Rocky Mountain Health Plans. If you would like to seek out-of-network reimbursement for therapy, please discuss this during your intake session.*

I understand that fees are due at the time of service. I authorize any service fees to be deducted from the credit/debit/HSA card listed below unless I produce an alternative form of payment at the time of service. 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: after entry, your credit card information will be shredded)

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