INTAKE FORM

Mark. E. Kilmer, PhD Licensed Psychologist (#2806) 5377 Manhattan Circle, Ste 201 Boulder, CO 80303-4345
Tel. (303) 995-1188 Fax (720) 304-6633 DATE: _____

PATIENT / INSURED
Last Name: _____ First: _____ M.I. _____
DOB: _____ Age: _____ Sex: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Tel. (_____)_____ Work: (_____)_____ Cell: (_____)_____
Social Security #: _____ Driver's License #: _____
Marital Status: _____ Former/Present Relationship(s)/ Marriage(s) (Years in relationship): _____
Children (step, grand, etc., names & ages): _____
_____
Sibling(s) (names & ages): _____
Parent(s) (names & ages with year of death, if applicable): _____
Employer:_____ Occupation/Position: _____
Address: _____ City: _____ State: ____ Zip: _____

GUARANTOR/ INSURED (if different from above)
Last Name: _____ First: _____ M.I. _____
DOB: _____ Relationship to Patient: _____
Social Security #: _____ Driver's License #: _____

INSURANCE (PRIMARY): Name of Insurance Co. _____
Address: _____ City: _____ State: ____ Zip: _____
ID#: _____ Group #: _____ Authorization #: _____

EMERGENCY CONTACT: _____ Tel. #: (_____)_____

PRESENTING PROBLEM(S) (include past/present alcohol, chemical or substance use/abuse/dependency):

_____

_____

PAST/PRESENT MEDICAL CARE (specify major problems, accidents, hospitalizations and current medications, including psychiatric): _____
Physician(s): _____ Tel. #: (_____) _____

PAST/PRESENT PSYCHOTHERAPY AND/OR MENTAL HEALTH HOSPITALIZATIONS:
Presenting Problem and Outcome: _____
_____

FAMILY HISTORY (Chemical Dependency, Mental Illness, Violence, Suicide): _____
_____

I authorize the release of medical/mental health information necessary to process insurance claims for current and future services. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the provider.

Print Name: _____ **Signature**: _____

Please use space on back of form for additional information.

OFFICE POLICIES AND GENERAL INFORMATION

Mark. E. Kilmer, PhD Licensed Psychologist (#2806)
5377 Manhattan Circle, Ste 201
Boulder, CO 80303-4345
Tel. (303) 995-1188 Fax (720) 304-6633

CONFIDENTIALITY:

- All information disclosed within clinical sessions and the written record pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: when there is a reasonable suspicion of child or elder abuse or neglect; when a patient presents a danger to him/herself or to others; or is gravely disabled.
- Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigations by yourself, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Mark Kilmer. When couples and/or families are in treatment together, different family members may, at times, be treated individually; in these circumstances, confidentiality and privilege do not apply between the couple or the family members. Dr. Mark Kilmer will use his clinical judgment if and when revealing such information.
- If, during treatment, there is a clinical emergency, or Dr. Mark Kilmer has reasonable concern regarding, the patient's ability to maintain his/her own personal safety, or the patient's possible risk of harm to another person, Dr. Mark Kilmer is ethically and legally required to exercise whatever actions, within the limits of the law, are possible to prevent the patient from injuring him/herself or others. For this purpose, Dr. Mark Kilmer may also contact the person listed on the Intake Form for emergencies.
- Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process claims. Only the minimum information necessary will be communicated to the carrier. Dr. Mark Kilmer has no control or knowledge of this information once submitted to the carrier.

TELEPHONE & EMERGENCY PROCEDURES:

- If you need to contact Dr. Mark Kilmer between sessions, please leave a message on the cell phone/ voice mail service at (303)995-1188, and your call will be returned as soon as is possible. If an urgent situation arises, please indicate this clearly in your message. If an emergency arises, and you need immediate assistance, leave Dr. Mark Kilmer a message, and call the Colorado Suicide Prevention Hotline at (800) SUICIDE, or in Boulder County (303) 447-1665, or emergency services by calling 911.

Initial: _____

OFFICE POLICIES AND GENERAL INFORMATION, (continued)

THE PROCESS OF TREATMENT/EVALUATIONS:

- Participating in psychotherapy can result in a number of benefits for a patient, including improving interpersonal relationships, and the resolution of specific concerns and/or problems that led a patient to seek treatment.
- Working toward these benefits, however, requires effort from the patient. Psychotherapy requires a patient's very active involvement, honesty, and openness in order to achieve the necessary cognitive/behavioral goals. Dr. Mark Kilmer will solicit patient feedback during treatment to monitor progress; patient honesty and openness can facilitate this process.
- During evaluation or treatment, remembering or discussing unpleasant events, emotions, or thoughts can result in a patients experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Attempting to resolve issues that brought a patient to treatment initially, such as interpersonal relationship, may result in changes that were not originally considered or intended. Psychological treatment may result in changes regarding behavior, employment, chemical/substance use, education, residency and relationships. Sometimes a patient's decision is viewed positively and/or negatively by others in the patient's family, personal, and/or workplace environment.
- Treatment goals may be achieved easily and swiftly, but more often the process will be slow and even frustrating. And there is no guarantee that psychological treatment will yield positive or intended results.
- During the course of treatment, Dr. Mark Kilmer will draw on various psychological treatment approaches, according to the presenting problem, and an assessment of what might best benefit the patient. The approaches include behavioral, cognitive/behavioral, psychodynamic, existential, family systems, developmental, or psycho-educations. If you have any questions regarding the procedures used in the course of treatment, any risks, Dr. Mark Kilmer's expertise in employing them, or about the treatment plan, please ask to receive a thorough explanation. You also have the right to inquire regarding other treatment procedures for your condition or problem and the possible benefits and risks.
- If a patient may benefit from a treatment procedure that Dr. Kilmer does not provide, Dr. Kilmer is ethically and legally obligated to assist a patient in obtaining those treatments.
- Dr. Mark Kilmer regularly consults with other mental health professionals regarding patient's treatments; however, patient's names and/or other identifying information are never mentioned: patient's identities remain completely anonymous, and confidentiality is fully maintained.
- At the end of the first or second treatment sessions Dr. Mark Kilmer will assess the potential benefit of treatment for the patient. Dr. Kilmer does not accept patients that are outside the scope of his competency; if this might become apparent, Dr. Kilmer will provide several referrals to contact for continuing treatment.
- If at any time a patient needs another professional opinion or wishes to consult with another clinician, Dr. Mark Kilmer will assist in locating a qualified practitioner; and, with the patient's written consent, will provide essential information needed.
- A patient has the right to terminate treatment at any time. If a patient chooses to do so, Dr. Mark Kilmer will offer to provide information for other qualified clinicians whose services might be preferred.

I have read, understand, and agree to comply with the above office policies:

Print Name: _____ **Signature**: _____

Date: _____

BILLING AND INSURANCE INFORMATION

Mark. E. Kilmer, PhD Licensed Psychologist (#2806)
5377 Manhattan Circle, Ste 201
Boulder, CO 80303-4345
Tel. (303) 995-1188 Fax (720) 304-6633

PAYMENTS & INSURANCE REIMBURSEMENT:

- Your payment or co-pay is due at the time of service; please remember to bring this with you to every visit. You will be charged a $10 per statement fee if co-pays are not received and a billing statement is required.
- Patients are required to pay the standard fee, one hundred twenty ($120.00) per forty five (45) minute session, at the commencement of each session, unless other arrangements have been agreed upon.
- Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, extended sessions, travel time, etc. will be charged at the standard fee rate, unless otherwise agreed upon.
- Please notify Dr. Kilmer if any problem arises during the course of treatment regarding your ability to make timely payments.
- Patients who carry insurance please note that professional services are rendered and charged to the patient and not to the insurance company.
- Dr. Kilmer will provide a monthly receipt as documentation to your insurance carrier for reimbursement.
- If you account becomes unpaid or overdue, and there is no written agreement for a payment plan, Dr. Kilmer may use legal means (court, collection agency, etc.) to recover all fees and collection costs due and payable.

CANCELLATION POLICY:

- Since the scheduling of an appointment involves the reservations of time specific for each patient, a minimum of forty eight (48) hours notice is required for rescheduling or canceling an appointment.
- If you reschedule, there is no cancellation time period available for a rescheduled appointment and you will be billed if you miss the appointment.
- The full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read, understand, and agree to comply with the above billing policies:

Print Name: _____ **Signature**: _____

Date: _____

DISCLOSURE STATEMENT

The State of Colorado requires that all psychologists provide their clients with the disclosure below. Please read this page and ask me any questions you may have at this time about the information presented. Then, please sign your name in the space provided to indicate that you have read the disclosures.

INFORMATION

Mark E. Kilmer, PhD
5377 Manhattan Circle, Suite 201
Boulder, CO 80303
303-995-1188

CREDENTIALS

I have and masters and doctorate degree in clinical psychology, which I received from Antioch University and the California Graduate Institute, Los Angeles, respectively, in 1998. My Colorado psychology license number is #2806. Before this, I was licensed in California (PSY 17133) since March, 2001.

My credentials include:

- The Colorado School for Family Therapy, Aurora, CO
  Certification in Child and Family Investigations ("CFI")
- University of California at Los Angeles, Neuropsychiatric Institute, Los Angeles, CA
  Certification in Psychoanalytic Couples Therapy. One year course studies; two years practicum.
- Department of Children and Family Services, Los Angeles, CA
  Certification in Child Abuse Assessment.
- Professional Academy of Custody Evaluators, Furlong, PA
  Trained in Comprehensive Custody Evaluation.
- California Graduate Institute, Los Angeles, CA
  Certification in Assessment, Diagnosis, and Treatment of Victims and Perpetrators of Violent Crime.
- Josephine Bernstein Research Award, for best theoretical dissertation study, California Graduate Institute, Los Angeles, CA (1998).

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 Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

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. Please ask if you would like to receive this information. My fee is $120.00 per hour for counseling.
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 Department of Regulatory Agencies.
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.

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 understand my rights as a client/patient. Dr. Kilmer read this disclosure out loud to me and I acknowledge that I have received a copy of this Disclosure Statement.

_____ _____

Client Signature/Legal Representative Date

_____ _____

Therapist Date

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  Certification in Psychoanalytic Couples Therapy. One year course studies; two years practicum.
- Department of Children and Family Services, Los Angeles, CA
  Certification in Child Abuse Assessment.
- Professional Academy of Custody Evaluators, Furlong, PA
  Trained in Comprehensive Custody Evaluation.
- California Graduate Institute, Los Angeles, CA
  Certification in Assessment, Diagnosis, and Treatment of Victims and Perpetrators of Violent Crime.
- Josephine Bernstein Research Award, for best theoretical dissertation study, California Graduate Institute, Los Angeles, CA (1998).

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I have read the preceding information and understand my rights as a client/patient. Dr. Kilmer read this disclosure out loud to me and I acknowledge that I have received a copy of this Disclosure Statement.

____***Copy for your records***_____

Client Signature/Legal Representative

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

Mark. E. Kilmer, PhD Licensed Psychologist (#2806)
5377 Manhattan Circle, Ste 201
Boulder, CO 80303-4345
Tel. (303) 995-1188 Fax (720) 304-6633

I, _____ authorize Mark E. Kilmer, PhD, to release information, verbally or in writing, related to clinical treatment with the person(s)/entities named below; and/or to receive any relevant information from the person(s)/entities named below:

- _____
- _____
- _____
- _____
- _____
- _____

I authorize this/these release(s) for the following reason(s): _____

_____

_____

_____

This consent may be revoked at any time. This consent shall be in effect for three (3) years from the date of the last session, unless revoked or renewed.

SIGNATURES:

Patient: _____ Date: _____

Patient: _____ Date: _____

Legal Guardian/Parent: _____ Date: _____