Lori C. Kucharski, MA, LMFT, LPC
AAMFT-Approved Supervisor, Certified EMDR Therapist & Consultant
1757 S. 8th Street, Suite 120; Colorado Springs, CO 80905
Cell: 719-360-2440; Fax: 855-641-5882
LoriKucharski@emdrcenterofthepikespeakregion.com

Client Information Form

Client Name: _____ DOB:_____ Age: _____
Home Address:_____ City:_____ State:____ Zip:_____
Home Phone: (_____) _____ Cell Phone: (_____)_____ Identified Gender: _____
Occupation: _____ Referred by: _____
Parent/Guardian Names (if minor): _____
E-mail: _____ Mailing Address: _____

Do you have children (Or, if client is a minor, does client have siblings)? *Yes* *No*
Names, Ages, and Custodial Arrangements:

What are your reasons for seeking counseling at this time?

Have you/child ever been seen by a mental health professional before? *Yes* *No*
Have you/child ever been hospitalized for mental health or subs*tance abuse reasons? Yes No*
Have you/child ever had psychological testing? Yes No Results?_____
If yes to the above questions, please indicate who, when, and why:

Primary physician: _____ Location: _____ Phone #: (____)_____
Date of Last Physical: _____ Results: _____
Please list any significant medical conditions you may have:

_____
Please list your current and past medications (Including Psychiatric; Prescription & Non-Prescription):
Drug Dose Frequency Start Date End Date Used for Diagnosis Prescriber

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Who should be notified in case of emergency?
Name: Relationship: Cell Phone:

What current symptoms are you experiencing? (e.g.: nightmares, insomnia, lethargy, increase in energy, problems with attention/memory/concentration, low self-esteem, appetite gain or loss, sadness, low energy, self-harm, flashbacks, anxiety, stress, anger, weight gain or loss, hypervigilance, easily startled, phobias, substance abuse, behavior problems, relationship difficulties, suicidal thoughts, homicidal thoughts, addictions, caffeine increase, etc), and for how long?

Are you currently suicidal? *Yes No*
Have you ever attempted suicide: *Yes No*
Has anyone you care/d about ever attempted or completed suicide? *Yes No*
Have you or a family member/loved one experienced an addiction? *Yes No* (If so, to what substances or behaviors? _____)
Do you have a trauma history? *Yes No*
If so, have you ever been abused or neglected in any way? *Yes No*
Approximate age(s)/event(s): (*If preferred, this can be shared face-to-face)*

What was your family of origin like? Current/identified family?

What sustains you in difficult times of stress (e.g., exercise, journaling, etc)?

Do you have a preferred religion or spiritual belief?

What are your hobbies? Strengths? Support system?

Anything else I should know? Any questions for me?

Signed:		Date:	

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Disclosure Statement

Client Name:	

I attended Bethel College in Mishawaka, IN and received an MA Degree in Counseling/Marriage and Family Therapy in 2005. I am certified through EMDRIA as an EMDR Therapist, Consultant, and Trainer and am certified in Sandtray therapy through the Colorado School for Family Therapy. I an AAMFT-Approved Supervisor. I am currently obtaining my PhD in Counselor Education and Supervision.

Regulation of Psychotherapists
The practice of licensed or registered persons in the field of psychotherapy is regulated by the Division of Professions and Occupations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800. While I hope we can openly discuss any concerns you could have, if you feel this is not feasible, you may file a complaint at https://www.colorado.gov/pacific/dora/DPO_File_Complaint. 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 Master's Degree in their profession and have at least two years of post-Master's supervision.

Your Rights as a Client

a. You are entitled to receive information from me about my methods of therapy and the techniques I use, length of sessions, and treatment recommendations. While I have been trained in most therapy modalities, ones I use regularly include EMDR, CBT, DBT, SFBT, Family Systems Therapy, Emotion-Focused Couples Therapy, IFS, experiential therapy (including art and sandtray therapy), and/or narrative therapy. Sessions are generally :50-55 minutes and take place 2-4x a month.
b. You can seek a second opinion from another therapist or terminate therapy at any time.
c. In a professional and therapeutic relationship, sexual intimacy between a therapist and a client is never appropriate and must 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 the following: I am required to report any suspected or confirmed incident of child abuse or neglect (please note--this applies even if the victim is now over the age of 18 if the perpetrator(s) may be in positions of trust); I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; 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; I am required to report any suspected threat to national security to federal officials; I am required to report suspected or confirmed abuse of a senior who is 70 years of age or older, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and I may be required by Court Order to disclose treatment information.
e. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I will disclose to law enforcement officers information about my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.
f. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children ages 14 and under unless the court has restricted access to such

information. If you request treatment information from me, I will provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

g. Regarding video or audio recording, I agree not to record our sessions without your written consent, and you agree not to record any session or conversation with me without my written consent.

Divorced or Divorcing Parents 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.

If you are seeking therapy services with me for a child age 14 or younger, and if you and the child's other biological parent are divorced, I must receive copy of the divorce decree prior to meeting with the child to determine who has decision-making rights. Generally, decision-making rights are awarded to both parents, even if one has primary physical custody. In these situations, I must have the signatures of both biological parents (including the non-custodial parent) on the Disclosure Statement and HIPAA/Privacy Rights Notice and a copy of the non-custodial parent's identification (such as a driver's license). If this is not possible (for example, one parent is deceased, incarcerated, or missing), please discuss this with me.

If parental rights have not been terminated for the non-custodial parent, they are entitled to receive information about the child's therapy. In such situations, I provide each biological parent with an updated treatment summary at intervals determined to be clinically appropriate (to the extent that it does not breach the child's confidentiality and safety). It is also best that, if both biological parents are involved, any email communication take place amongst all parties as needed and appropriate.

In cases of remarriage of a biological parent when a minor is age 14 or younger, I may not disclose information to a step-parent without a signed release of information from both biological parents. Transportation by the step-parent to and from session is permissible, but in these situations, I require biological parents to remain communicative and part of the therapeutic process. At times, I may also request that all adult parties participate in family therapy, if needed, to work together for the minor child's best interest.

Informed Consent

Therapy can benefit you in many ways, including reducing uncomfortable symptoms and improving relationships.These benefits may require a significant amount of effort and willingness on your part. I will frequently ask for your feedback on therapy and our progress.

You may notice that your symptoms seem to feel worse at times. This may be normal as you begin to address different aspects of what has been troubling you. Resolving issues that brought you into therapy may bring about unintentional changes in relationships, behavior, substance abuse, etc,, and as you experience growth, others could potentially experience negative responses to your change. Sometimes change may happen quickly, but often, it can take time to get to where you would like to see yourself. As always, there is no guarantee that therapy will demonstrate results, but it is my responsibility to use methods that have been shown to be effective in treating presenting issues such as your own.

It is important to me that you feel I am with you through this process. If for any reason either of us determines I may not be the best clinical fit, or if you have needs outside my areas of expertise, you are entitled to a referral to another provider.

At all times, you are entitled to an evaluation with a psychiatric provider to determine if medication may benefit you. I will gladly help you with this process and will respect your wishes, except in certain, necessary circumstances, if you do not desire to use a pharmaceutical approach. My approach to counseling is holistic by nature, and I often refer clients who wish to use non-pharmaceutical interventions to their primary care physicians, naturopathic physicians, functional medicine practitioners, and/or those who assist in mind/body work, such as acupuncturists, massage therapists, and yoga trainers.

Couples and Family Therapy
It is my policy when doing couples and family work to maintain a "no secrets" policy. This means that I will not speak to one party without the other(s) present unless it is solely regarding scheduling or payment. Any conversations about treatment and related topics need to happen in the office together. Likewise, I will not see one person for therapy if not all parties are present. If one member of the couple or family no-shows or late-cancels an appointment, a no-show fee will be charged, and the appointment will be rescheduled.
In family therapy, I may be working with the primary client (such as a child) individually while also providing family counseling. In this situation, the primary client's privacy would be maintained unless a breach in confidentiality was warranted, or a release was signed allowing such for necessary treatment.

Crises or Emergencies
Should a crisis arise (a situation not requiring immediate attention or care, usually addressed within the next few days), please leave me a voicemail in my confidential inbox on my cell phone or send an email to lorikucharski@emdrcenterofthepikespeakregion.com. I will attempt to return all calls or emails within one business day (not on weekends or holidays). Should your situation escalate to emergent, or should you experience an emergency, please call 911 or have someone take you to the nearest emergency room.
In case of my own emergency or crisis, I may not be able to reach you in a timely manner before your appointment. In this unforeseeable situation, I will do my best to communicate with you as soon as possible. In case of a prolonged emergency, in which you may need to seek another therapist in the meantime, therapists I often refer to include Jen Baumgardner, LCSW; Melanie Protzmann, LPC; & Cynthia Crawford, LCSW.

Vacations
Occasionally, I may take non-traditional days off of work. If I am out of the county and/or am unavailable for an extended period of time, I will leave an outgoing message on my cell phone and an away message on my email stating such. For extended leaves, another therapist may be accessible to you (this will generally be established before I depart).

Use of Technology
I prefer that we do not use text messaging (as it is never guaranteed secure) for anything other than scheduling purposes and primarily use voice mail and/or email for all private or personal matters related to your therapy. Please be aware that while I take proper precautions to ensure confidentiality, security, and privacy, I may not guarantee such with any such communications. When possible, I use HIPAA-compliant software or platforms. All methods of communication also become part of your permanent file.
With your Electronic Health Record (EHR) and Protected Health Information (PHI), all information is stored on an encrypted cloud, and billing is submitted electronically and securely. All PHI and EHR information maintains HIPAA compliance (encryption, password protection, minimum of 2 locks, etc). I take privacy seriously and take significant precautions to protect your information.

It is my policy to not engage with clients on social media due to legal statutes and codes of ethics to

which I belong.

Distance Counseling

While face-to-face therapy is preferred, I realize it is not always easily accessible or achievable for a variety of reasons. In these situations, I do offer distance therapy, or teletherapy, via a HIPAA-encrypted software platform. There are unique risks and benefits to obtaining distance counseling. Benefits include being able to access care while being house-bound or living in a very rural area, weather problems, etc. Risks include the inherent, increased risk of privacy breaches, as well as my inability to access, at times, needs as accurately as when face-to-face. Another risk is technology failure (due to storm outages, DSL going down, etc.). In these situations, I will do my best to reach out to you as quickly as possible, and use of phone may be a possibility.

Anti-Discrimination Clause

I am committed to maintaining a therapeutic and supervisory practice which recognizes and values the inherent worth and dignity of every person; fosters tolerance, sensitivity, understanding, and mutual respect among its members; develops and nurture diversity; and encourages each individual to strive to reach his or her own potential. I believe that diversity strengthens therapy and supervision, stimulates creativity, promotes the exchange of ideas, and enriches life.

I view, evaluate, and treat all persons in any therapeutic or supervisory activity or circumstance in which they may be involved, solely as individuals on the basis of their own personal abilities, qualifications, and other relevant characteristics.

I prohibit discrimination against any individual on the basis of race, religion, color, sex, age, national origin or ancestry, genetic information, marital status, parental status, sexual orientation, gender identity and expression, disability, or status as a veteran. I will conduct my programs, services and activities consistent with applicable federal, state and local laws, regulations and orders and in conformance with the procedures and limitations as set forth.

*Used with gratitude towards Purdue University

I have read this Disclosure Statement, understand the disclosures that have been made, and acknowledge that a copy of it has been made accessible to me. I hereby consent to treatment for myself or my dependent child.

Please print and sign name above **Date**

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HIPAA Privacy Statement: Notice of Privacy Rights

This notice contains information concerning how confidential mental health treatment information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully and let me know if you may have questions about this notice. During the process of providing services to you, I may obtain and use mental health and medical information concerning you that is both confidential and privileged. Ordinarily, this confidential information will be used in the manner that is described in this statement, and will not be disclosed without your consent, except for the circumstances described in this Notice.

I may use and disclose protected health information in the following ways:
Treatment. Treatment refers to the provision, coordination, or management of mental health care and related services by one or more health care providers. For example, I may use your information to plan your course of treatment and consult with other health care professionals or their staff concerning services needed or provided to you.
Payment. Payment refers to the activities undertaken by a healthcare provider to obtain or provide reimbursement for the provision of health care. For example, I will use information that identifies you, including information concerning your diagnosis, services provided to you, dates of services, and services needed by you, and may disclose such information to insurance companies and to businesses that review bills for health care services and handle claims for payment of health care benefits in order to obtain payment for services.
Health Care Operations. Health Care Operations means activities undertaken by health insurance companies, businesses that administer health plans, and companies that review bills for health care services in order to process claims for health care benefits. These functions include management and administrative activities. For example, such companies may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and Accreditation, certification, licensing and credentialing activities.
Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
Required by Law. I will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect to the Department of Human Services or to law enforcement; (b) when court ordered to release information; (c) when there is a legal duty to warn of a threat that a client has made of imminent physical violence, health care professionals are required to notify the potential victim of such a threat, and report it to law enforcement; (d) when a client is imminently dangerous to herself/himself or to others, or is gravely disabled, health care professionals may have a duty to hospitalize the client in order to obtain a 72-hour evaluation of the client; and (e) when required to report a threat to the national security of the United States.
Health Oversight Activities. Your confidential, protected health information may be disclosed to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.
Crimes on the premises. Crimes that are observed by me or those in this geographical area that are directed towards others and/or occur on premises will be reported to law enforcement.
Business Associates. Confidential healthcare information concerning you provided to insurers or to plans for purposes or payment for services that you receive may be disclosed to business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing and practice management services may be

provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
Research. Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA Privacy Regulations are followed.
Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed in compliance with Colorado law.
Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.
Emergencies. In life threatening emergencies I will disclose information necessary to avoid serious harm or death.
Client Release of Information or Authorization. I and other health care professionals may not use or disclose protected health information outside of the limits to confidentiality without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

Your Rights as a Client
**To make any of the following requests, please ask me for the appropriate request form.*
Access to Protected Health Information. You have the right to receive a summary of confidential health information concerning you concerning mental health services needed or provided to you. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies.
Amendment of Your Record. You have the right to request that I amend your protected health information. I am not required to amend the record if I determine that the record is accurate and complete.
Accounting of Disclosures. You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting.
Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. I do not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request.
Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from me by alternative means or at alternative locations. For example, if you do not want me to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process.
Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

Technology and Communication

E-mail Communications. Unencrypted e-mail may not be confidential, and any information regarding PHI sent by e-mail may not be confidential.
Skype, Facetime, Other Similar Video Conferencing Technology, and Internet Communications. Communication and counseling through these means may not be confidential.
Storage of Healthcare Information. Health care records and information maintained on a Cloud may not be confidential, depending on the number of servers involved.
Voicemail. Telephone messages left through voicemail may not be confidential, if they may be accessed by individuals other than the client. Please let me know if you do **not** want me to use voicemail in contacting you.
Facsimile Communication. The submission of health care information or records by fax may not be confidential, and may lead to a disclosure of confidential information to third parties if the wrong fax number is used to send the information.
Communication by U.S. Mail. Communication of information by U.S. mail may lead to disclosure of private information to third parties, depending on who may open the mail. Please let me know if you do **not** want me to send you correspondence, billing invoices, or other information through the U.S. mail.

Privacy Laws. I am required by State and Federal law to maintain the privacy of protected health information. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.
Terms of the Notice and Changes to the Notice. I am required to abide by the terms of this Notice, or any amended Notice that may follow. I reserve the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in my service delivery site and/or my website www.emdrcenterofthepikespeakregion.com, and will be available upon request.
Complaints Regarding Privacy Rights. If you believe that I violated your privacy rights, you have the right to file a formal statement to me. Please submit a statement, in writing, addressed to me, concerning your complaint and the basis for it. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is my policy that there will be no retaliation for your filing of such complaints.
Additional Information. If you desire additional information about your privacy rights, please ask me any questions that you may have.
Confidentiality of alcohol and drug abuse records. The confidentiality of alcohol and drug abuse patient records maintained by me are protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless the patient consents in writing, the disclosure is allowed by a court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
Violation of the Federal Law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the office site or against any person or about any threat to commit such a crime. Disclosure may be made concerning any threat made by a client to commit imminent physical violence against another person to the potential victim who has been threatened and to law enforcement.
Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

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This notice is effective August 3, 2016.

I understand these disclosures. I have accessed, reviewed, and had an opportunity to ask question about this Notice of Privacy Rights. I understand I am able to access these Rights in writing at any time.

Please sign your name above. **Date**

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Payment Contract

Client Name:		DOB:		Responsible Party's SSN:	

I understand that I will be responsible for payment for the services provided for me or my dependents and that my portion of the charges are to be paid at the time of service. I will provide information on any change of insurance or coverage status immediately and understand that if my benefits are terminated, I am financially responsible for full payment of services at the private-pay rate for those dates of service.
I authorize the release of any information necessary to process my claim to my insurance company or other third-party payer identified below. I understand that this may include mental health diagnoses, assessments, treatment plans, progress notes, and information about drug or alcohol abuse or HIV status. It may also include the release of information for the determination of eligibility or coverage and adjudication or subrogation of health benefit claims. It may include billing, claims management, collection activities, obtaining payment under a contract for reinsurance and related health care data processing. It may include at third party payer's review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges. I understand that this information may also be released to any billing services. I understand that it is my responsibility to obtain information about my benefits from my insurance company and that I will be responsible for any costs insurance does not cover, including,, but not limited to, case management, report writing, consultation, testimony, no-show fees, or late-cancellation fees. I understand that if I neglect to pay my bill, I will be responsible for a collections fee if my bill is sent to collections, and I will be fully responsible for all associated legal, court, and attorney fees. I authorize my insurance company to make payments to Lori Kucharski/EMDR Center of the Pikes Peak Region, LLC and understand that Lori Kucharski has contracted with my insurance provider to accept fees at a rate which may be below the usual fee for service.

No-Show/Late Cancellation Policy
I understand that I am responsible for payment of any missed appointments that are not cancelled by 8AM **for any reason** the morning of the scheduled appointment. I will attend appointments on-time and will communicate if I am running late (including notification if any impediment keeps me from arriving to my appointment as scheduled); I understand that an appointment for which I am more than 10 minutes late may need to be rescheduled, and I may be charged a late-cancel/no-show fee. I understand that I will be charged $65 in accordance as a client and/or parent/guardian complying with this No-Show/Late Cancellation Policy. I am aware that multiple missed appointments may result in the termination of therapy.

Balance Due Policy
It is this clinician's policy to maintain a credit or debit card on file in case of an outstanding balance. understand that my credit/debit card information will be kept in a secure, confidential file This card will be billed if I encounter a bill due to non-payment of services for any reason. A SSN is required to have on file in the event that a bill would go to collections. If you prefer not having a SSN on file, you may maintain a credit of $65 to your account in the event of a late cancellation or no-show charge. This credit will be returned to you within 30 days of terminating therapy and requesting a refund in writing.
The card I wish to have on file and am authorized to use is:

Card Number Expiration Date CCV

(Initial) _____ Private-Pay: I understand that I am responsible for payment in full at time of service at the

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rate of $ 85 per clinical hour.

(Initial) _____Insurance/Third Party: I request insurance or third-party reimbursement under my policy with company_____ under policy #_____**(if you use Tricare, please put sponsor's SSN on this line)**, or any other insurance or third party coverage which I might be authorized for, be made on my behalf to Lori Kucharski, MA, LMFT, LPC and/or EMDR Center of the Pikes Peak Region, LLC. Based on my insurance policy, my outpatient copay, deductible, or coinsurance is determined by my insurance company. I understand that I will be responsible for the full amount of the usual fee if I fail to take the necessary steps to obtain insurance payment for Lori Kucharski, MA, LMFT, LPC. I hereby authorize Lori Kucharski, MA, LMFT, LPC to submit claims on my behalf to my insurance company or third party carrier for all services I or my dependents receive from Lori Kucharski, MA, LMFT, LPC.

(Initial)_____Case Management, Report Writing, and/or Testimony
I recognize that, at times, case management (contacts made to/from me or on my behalf) may be necessary as part of my therapeutic care. I recognize that this contacts with me or with collaterals will be charged in 15-minute increments at a rate of $105/hour. This applies to Social Security or Disability report writings, completion of treatment summaries, phone calls exceeding :10 minutes, case consultations with other providers or institutions, and/or any other therapeutic services not covered under health insurance or third-party coverage. While I have signed a waiver that I will not call this clinician to court, if I do so, I am aware that her court fees are $250/hour minimum for preparation, consultation, debriefing, and testimony, or any other related court costs. I am aware I may request a full Trial Fee Schedule and will be required to place a retainer of $1,000.00 on file (minimum) upon Lori Kucharski (or DBA) receiving a subpoena.

I have had opportunities to discuss my payment contract and ask questions. I understand that I am entitled to a copy of this document. This document will remain in effect as long as I am a client of Lori Kucharski, MA, LMFT, LPC and EMDR Center of the Pikes Peak Region, LLC.

Responsible Party Signature:		Date:	

Must also be signed by any other party whose credit card is on file.

Please include a picture of Driver's License and Insurance Card

Driver's license verified: *Yes* *No*	Insurance Card Verified: *Yes* *No*

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Authorization for Coordination of Healthcare

Please complete this form if you wish to authorize to exchange information regarding your behavioral health condition to your primary care provider or other behavioral health providers who may be involved in making decisions regarding your healthcare. This form may be revoked in writing at any time.

_____

Client Name **Date of Birth**

_____

Doctor's Name

_____

Office Address

_____

Office Phone Number/Fax Number (if known)

_____ **Date:** _____

Client/Legal Guardian Signature

_____ **I do <u>not</u> want to have information shared with my other healthcare provider(s), or I do not currently have any other healthcare provider(s).**

To be completed by Lori Kucharski, MA, LMFT, LPC:

Current Diagnosis/es:_____

First Date of Service:_____ **Frequency of Appointments:**_____

Treatment Goals:_____

_____

Comments:_____

_____

_____ _____

Lori Kucharski, MA, LMFT, LPC **Date**

Lori C. Kucharski, MA, LMFT, LPC
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LoriKucharski@emdrcenterofthepikespeakregion.com

Treatment Plan

Client(s):		Date:	

DSM 5 Diagnoses (to be completed by therapist):

My (or my child's) long-term goals include:

Anticipated Strengths:

Anticipated Obstacles:

Others will be able to tell that I have accomplished this goal when:

Therapeutic Interventions (to be completed by therapist): Individual, Family, and/or Group therapy sessions to be attended at a frequency of 1 hour _____ times per _____.
Treatment modality: _____

Signatures:

Client(s) or Parents/Guardians:	Date:
Lori Kucharski, MA, LMFT, LPC:	Date: