

**Krupnick Counseling Associates**  
500 Kimbark St. Suite 200, Longmont, CO 80501 303-651-1515

**Mandatory Disclosure Statement**  
(required by C.R.S. 12-43-214)

**LOUIS B. KRUPNICK, Ed.D.**

Degrees: Doctor of Education, Integrative Psychology  
University of Northern Colorado

License: Licensed Psychologist, Colorado #1832

Member: Colorado Psychological Association  
Employee Assistance Professional Association  
Society for Clinical and Experimental Hypnosis

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 Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800. As to the regulatory requirements applicable to mental health professionals: 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 or 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 yours and 1,000 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 registered with the State Board of Registered Psychotherapists, is NOT licensed or certified, and no degree, training or experience is required.

You are entitled to receive information from me about my methods of assessment and therapy, the techniques I use, my fee structure, and the duration of your therapy if I can determine it. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by the client during therapy sessions is legally confidential, and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are provided in section C.R.S. 12-43-218 and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

**I have read the preceding information, it has also been presented verbally, and understand my rights as a client.**

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or guardian (if applicable)

**KRUPNICK COUNSELING ASSOCIATES**  
**CONFIDENTIAL CHILD INTAKE INFORMATION**

**CONTACT INFO**

Client Name (Child/Adolescent)	Date of Birth	Age	M/F
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Present Street Address	City	Zip Code
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Home Phone	Work/Cell Phone	Email address
O.K. to Call    Yes    No	O.K. to Call    Yes    No	O.K. to Email    Yes    No

Mother's Name	Mother's Address (if different from above)	Home Phone / Cell Phone
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Father's Name	Father's Address (if different from above)	Home Phone / Cell Phone
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Name of Parent with Legal Custody	Name of Child's School / Teacher
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**INSURANCE INFO**

Will we be billing insurance on your behalf?    Yes    No

**If yes, please complete the following section about your insurance and carefully read our billing agreement**

Policy Holder's Name	Policy Holder's DOB	Policy Holder's Social Security #
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Insurance Company Name	Insurance ID#	Insurance Phone #	Policy Holder's Employer
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**MEDICAL/MENTAL HEALTH INFO**

Presenting Problem (What brings you here now?)

How long has the problem persisted?

Previous Counseling?    When?    With whom?

Child's Physician	Current Illnesses:	Current Medications:
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**HOUSEHOLD INFO**

Family Members (siblings, parents, others living in the home)

Name	Age	Relationship	Grade/Occupation	Living at home?
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**I, \_\_\_\_\_, am a legal guardian of the above named child and I authorize an evaluation and/or treatment of my child.**

Parent Signature	Date
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# Krupnick Counseling Associates

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## PAYMENT POLICY

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We ask that you make full payment at the time of service unless you have contacted our billing office or have provided a copy of your insurance card to our staff.

**If you have health insurance that will pay a portion of our fee we ask that you make your co-payment at the time of each visit. Health insurance is a contract between you and your insurance company and you are still responsible for any services that are rendered on your behalf.**

If you have any questions about our fees or office procedures, please bring them to our attention.

We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. In many of these families the question of who is responsible for the children's medical bill is uncertain. **The policy of our office is that the parent who requests treatment for the child is responsible for all fees incurred.**

Collection procedures will be initiated when payments are past due. The responsible individual agrees to pay all collection fees, including attorney's fees, court costs and other expenses incurred in the collection of delinquent accounts.

### FEE SCHEDULE FOR KRUPNICK COUNSELING ASSOCIATES

Initial assessment or extended session	60 minutes	\$150.00
Psychotherapy	45 minutes	\$130.00
<b>1<sup>st</sup> Missed Appointment / Late Cancel</b>		<b>\$70.00</b>
<b>Additional missed appointments/late cancellations</b>		<b>\$130.00</b>

**If you need to cancel an appointment, kindly give us a minimum of 24 hours notice. Exceptions will be made when circumstances exist such as sudden illness or when weather conditions make it impossible to get to your appointment.**

**Please note:** insurance companies do not reimburse us for missed appointments and late cancellations. You will be billed directly.

Other services that require more than 15 minutes are billed **directly to you** at the rate of \$100 per hour. These services include:

1. Telephone consultations with you or others (with prior authorization from you).
2. Review of records such as prior treatment reports, custody evaluations and the like.
3. Reports and letters to others (which are only provided at your written request).
4. Expert testimony for depositions and/or court appearances, including travel and preparation time if necessary (50% of the anticipated fee for these services must be paid one week in advance).

**By signing below, the undersigned certifies that (s)he has read and understands our payment policy and is financially responsible for services rendered by Krupnick Counseling Associates.**

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Responsible Party

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Date

**Krupnick Counseling Associates**  
500 Kimbark Street, Suite 200, Longmont, CO 80501

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS**

**Name of client:** \_\_\_\_\_

**I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**If not the client, please print your name and state your legal authority to sign for the client:**

\_\_\_\_\_

**••• For Provider Use Only •••**

The Notice of Privacy Rights was presented to the client or legal guardian today, but the client or legal guardian did not sign this acknowledgement because:

\_\_\_ **The client refused to sign**

\_\_\_ **The legal guardian refused to sign**

\_\_\_ **The client or legal guardian was incapable of signing**

\_\_\_ **Other reason:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of provider**

\_\_\_\_\_  
**Date**

**Krupnick Counseling Associates**  
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**NOTICE OF PRIVACY RIGHTS**

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During the process of providing services to you, the provider will obtain, record and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as describe below.

The provider will use and disclose protected health information in the following ways:

1. *Treatment.* Treatment refers to the provision, coordination or management of health care [including mental health care] and related services by one or more health care provider. For example, the provider will use your information to plan your course of treatment. The provider may consult with professional colleagues or ask professional colleagues to cover calls or the practice for the provider and will provide the information necessary to complete those tasks.
2. *Payment.* Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and, with your consent, provide information to your insurance company or other third party payer for provided services. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name and other information about your condition and treatment.
3. *Required by law.* The provider will disclose protected health information when required by law. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely impaired; (e) when a coroner is investigating the client's death; or (f) 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, or regulatory compliance.
4. *Crimes on the premises or observed by the provider.* Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or the provider's staff, or crimes that occur on the premises will be reported to law enforcement.
5. *Business associates.* Some of the functions of the provider may be provide by contracts with business associates. For example, some of the 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.
6. *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.
7. *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.
8. *Emergencies.* In life threatening emergencies the provider will disclose information necessary to prevent serious harm or death.

The provider may not disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization or a release of information, you may later revoke that authorization; provide that you do so in writing.

**NOTICE OF PRIVACY RIGHTS – page 2**

**YOUR RIGHTS AS A CLIENT**

1. *Access to protected health information.* You have a right to inspect and obtain a copy of the protected health information the provider has regarding you. You do not have a right to inspect or obtain a copy of the psychotherapy notes of your provider. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitations apply. To make a request to inspect or obtain a copy of health information pertaining to you, ask your provider.
2. *Accounting of disclosures.* You have a right to receive an accounting of disclosures the provider has made regarding your protected health information.
3. *Alternative means of receiving confidential communications.* You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this information be sent to another address. Also, you can request confidential information be communicated to you through the use of e-mail, fax transmission or voice mail messages.
4. *Complaints regarding privacy rights.* If you believe the provider has violated your privacy rights, you have the right to complain to the provider. 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.