



Heather Kuhl, Psy.D., LMFT

CLIENT HANDBOOK

Heather N. Kuhl, Psy.D., LMFT is the founder and director of Kuhl Psychological Services. Kuhl Psychological Services provides a variety of psychological services for children, adolescents, and adults including therapy, comprehensive psychological and psychoeducational evaluations, and gifted testing. Dr. Kuhl has a Master's degree in Marriage and Family Therapy from the University of Miami and a Master's and Doctoral degree in Clinical Psychology from Nova Southeastern University. Dr. Kuhl is a Licensed Psychologist (PY 8867) and Marriage and Family Therapist (MT 2695) in the State of Florida. Dr. Kuhl is also an avid equestrian, and has merged her passion for working with horses and people by becoming a Certified Equine Assisted Therapist through the Equine Assisted Growth and Learning Association (EAGALA).

At Kuhl Psychological Services, Dr. Kuhl focuses her practice on conducting psychological and psychoeducational evaluations primarily with children, adolescents, and young adults. Dr. Kuhl has experience in the assessment of giftedness, learning difficulties, intellectual disabilities, communication disorders, Attention-Deficit/Hyperactivity Disorder, Autism Spectrum Disorders, mood and anxiety disorders, and disruptive behavior disorders. Aside from conducting psychological evaluations, Dr. Kuhl has extensive experience providing therapy to children, adolescents, adults, and families, as well as with diverse populations such as veterans and survivors of torture. Clinical areas of expertise includes substance abuse, disruptive behavior, anger management, social skill training, academic problems, adjustment difficulties, parenting issues, family conflict, marital conflict, and mood and anxiety disorders.

APPROACH TO TREATMENT

When conducting evaluations, Dr. Kuhl utilizes a systematic approach, considering the context, such as the family and the school, and not just the individual. Initially, Dr. Kuhl conducts a clinical interview with the parents and/or individual depending on his or her age. Once the current concerns are clearly understood, an individualized test battery is selected, designed to assess the client's strengths and weaknesses, and to help answer any questions the individual or family may have. When problems arise at school, either academically, behaviorally, or socially, Dr. Kuhl may conduct a school observation to get a first hand view of the child in the academic setting. After all collateral information is gathered and testing is completed, a final report is written and reviewed with the client and/or the client's family to ensure understanding and discuss recommendations.



Dr. Kuhl's approach to therapy is also individualized, meeting the needs of each unique client or family. Dr. Kuhl utilizes current research and evidence-based treatments to inform her therapy. Regardless of the approach or techniques used, Dr. Kuhl believes a strong therapist-client relationship is key to therapeutic success, therefore, her goal is to create a safe and supportive environment where she can communicate caring and empathy. In instances, when Dr. Kuhl believes she may not be the best fit for the client/family, a referral will be made to other professionals who may be better equipped to serve the client/family.

Throughout Dr. Kuhl's clinical endeavors, she has enjoyed assisting parents discover why their children seem to be struggling academically, socially, emotionally, or even behaviorally. Similarly, Dr. Kuhl has worked with college students looking to better understand their strengths and weaknesses so they can succeed in life. Regardless of the reason for seeking services, Dr. Kuhl is passionate about helping individuals and families to find answers and solutions in order to improve their lives.

CONFIDENTIALITY

You have a right to confidentiality, whereby information between you and me during treatment will be kept strictly confidential and will not be revealed to anyone without your written permission. Therefore, you will be in charge of what information may or may not be disclosed. The law provides for the following exceptions to this provision, and under these circumstances, confidentiality will be breached:

1. If I suspect or have knowledge of child, disabled, or elder abuse, as a mandated reporter in the State of Florida, I must breach confidentiality and make a report to the necessary agency.
2. If I have reasonable cause to believe that you pose a risk of imminent harm to yourself.
3. If I have reasonable cause to believe that you pose a risk of imminent harm to another person.
4. If I receive a valid court order to testify on your behalf. However, in this case, I will state that communication is privileged, and testify only once you had the opportunity to acquire a court order protecting the confidential information.

RELEASE OF INFORMATION

There are several instances in which you may wish to waive confidentiality for the benefit of your treatment.



1. For psychological consultations. You hereby grant me permission to consult with your previous psychologist, therapist, or counselor. You authorize the use and disclosure of information from your previous clinician to me. Please provide the contact information for your psychologist, therapist, or counselor.

Name: _____
Phone number: _____

2. For psychiatric consultations. You hereby grant me permission to consult with your psychiatrist. You authorize the use and disclosure of information from your psychiatrist to me. Please provide the contact information for your psychiatrist:

Name: _____
Phone number: _____

3. For medical consultations. You hereby grant me the permission to consult with your physician(s). You authorize the use and disclosure of information from your physician(s) to me. Please provide the contact information below:

Name: _____
Phone number: _____

Name: _____
Phone number: _____

4. For academic consultations and school observations. You hereby grant me the permission to consult with your child's school/teacher or teachers, as well as to conduct a school observation if needed. The purpose of an academic consultation includes gathering information related to the child's social, behavioral, and academic performance. Similarly, a school observation will permit me the ability to survey your child's academic setting and performance. You authorize the use and disclosure of information from your child's school/teacher or teachers to me. Please provide the contact information below:

Name of School: _____
Phone number: _____

5. To the referral source. You hereby grant me permission to contact the referring individual or agency for the purpose of consultation and to benefit your current treatment with me. Please provide the contact information below:

Name: _____
Phone number: _____



PROFESSIONAL RECORDS

You should be aware that I keep information about you in two sets of professional records. One constitutes your Clinical Record. It could include information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that were set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, and reports of any professional consultations. You may receive a copy of the parts of your Clinical Record that I generate, if you request it in writing. If there is information from other providers in the Clinical Record that you would like a copy of, you will need to contact and obtain this information from the other provider who generated that material.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. (Note: Florida law allows a psychologist/clinician to provide the client with either a copy of the record or a summary. Upon your or your personal representative's written request, complete copies of your Clinical Record would be provided directly to a subsequent treating mental health professional). In most circumstances, there will be a charge for copying.

In addition, I may also keep a set of Psychotherapy Notes ("Notes"). These Notes are designed to assist me in providing you with quality care. While the contents of the Notes vary from client to client, they can include the contents of conversations, the analysis of these conversations, and how they impact your therapy. These Notes are kept separate from your Clinical Record. You may receive a copy of the Psychotherapy Notes that I generate, if you request it in writing. (Note: Florida law allows a psychologist/clinician to provide the client with either a copy of the record or a summary. Upon your or your personal representative's written request, complete copies of your Clinical Record would be provided directly to a subsequent treating mental health professional). In most circumstances, there will be a charge for copying.

CHILD AND ADOLESCENT TREATMENT

When children and adolescents are in treatment, whether for therapy or an evaluation, it creates a unique dilemma. While both parents have the right to be informed about their child's treatment, parental involvement may impact a child or adolescent's willingness to disclose confidential information and trust me in the process. Therefore, for the benefit of your child's treatment and to establish a therapeutic relationship, I will respect the confidence of your child or adolescent, so long as I believe it is in their best interest.



FAMILY AND COUPLES THERAPY

When families or couples are involved in therapy, the “client” is the relationship that joins the couple or family. Therefore, information disclosed within these sessions will not be disclosed to other family members who are not present. Further, when any participants in the relationship request and participate in individual therapy, information disclosed in this setting will not be shared among the couple or the family. However, in these situations, when information shared is pertinent to the treatment of the family or couple, the individual may be encouraged to share any necessary information with their loved ones.

REFERRALS

There may be times when making a referral to other professionals is necessary. Particularly when conducting psychological or psychoeducational evaluations, I often provide numerous referrals tailored to the needs of each client. My referrals are based on the reports from other clients or colleagues; and therefore, I cannot take personal responsibility for their competence.

VACATION AND ILLNESS

I may occasionally take time off when sick, on vacation, or to attend professional seminars. When possible, I will give advance notice and provide you with alternate days/times to reschedule sessions. In addition, during my absence I will provide you with contact information in the case of an emergency to a colleague or crisis center.

FEE AGREEMENT

You have requested a psychological/psychoeducational evaluation or counseling services from Heather Kuhl, Psy.D., LMFT which entails agreement with the following financial agreement.

1. Unless otherwise specified, a fee of \$2500.00 will be charged for a psychological/psychoeducational evaluation which includes the initial interview, testing, observation and/or consultation if needed, scoring and interpretation of tests, report writing, and a final feedback session to review the results of the evaluation and discuss recommendations.
2. Unless otherwise specified, a fee of \$500.00 will be charged for a gifted evaluation which consists of a brief interview, intelligence testing, scoring and interpretation of tests, report writing, and a final feedback session to review the results of testing and discuss recommendations.



3. Unless otherwise specified, a fee of \$200.00 will be charged for individual, family, or couple therapy, as well as an hourly fee of \$200.00 per hour for cross-professional consultations, conferences, and court appointments.
4. Full payment is due at the time services are rendered. In the case of gifted testing or a psychological/psychoeducational evaluation, full payment is due at the time of the initial interview, unless otherwise specified. Several insurance companies will reimburse for psychotherapy services that are out of their network, therefore, you may seek reimbursement directly from your insurance company. You are responsible for the bill at the time services are rendered, not the insurance company, however, I will provide you with the necessary forms and help you in obtaining insurance reimbursement.
5. A 24-hour cancellation policy is in effect for all clients. See below for cancellation policy.
6. When accounts are past due for more than 90 days, they will be turned over to a collection agency. In this case, if your account is past due, you agree to be financially responsible for all costs of collection (i.e., interest, court costs, sheriff fees, court fees, collection agency fees, attorney fees).
7. Please address any questions or concerns regarding these above stated fees with me when they arise.

CANCELLATION

Considering that time is reserved specifically for you, it is essential, that all appointments be kept promptly. When an appointment cannot be kept, Dr. Kuhl must be notified at least 24 hours in advance. If you do not cancel your scheduled counseling session, you will be billed the full session fee. In the case of a psychological/psychoeducational evaluation or gifted testing, a fee of \$75 will be charged for any appointment that is not kept or canceled 24 hours in advance. Emergency situations will be considered on a case by case basis at the discretion of Kuhl Psychological Services, Inc. and Dr. Kuhl.

EMERGENCIES

If you have an emergency, you can call me and leave a message which will be returned as promptly as possible. However, if you cannot reach me, you should call 211 or 911 immediately for crisis assistance. You can also contact, Henderson Mental Health Center Crisis Line, call Youth Crisis Services (954) 677-3113 or Adult Crisis Services (954) 463-0911, or go to your local emergency room.



Client Information

Name of Client: _____ Today's Date: _____

Person Completing Form: _____ Relationship to Client: _____

Age: _____ Date of Birth: ____/____/____

Parents' Names: _____

Parent's Marital Status: Married: ____ Divorced: ____ Single: ____ Separated: ____

Parents Occupation: _____

Address: _____

May I send mail to this address? ____ Yes ____ No

Home: _____ May I leave a detailed message? ____ Yes ____ No

Work: _____ May I leave a detailed message? ____ Yes ____ No

Cell: _____ May I leave a detailed message? ____ Yes ____ No

Current Living Situation: _____

Are you the legal guardian? ____ Yes ____ No

If not, who is the legal guardian? _____

Are you currently in the process of a divorce process? _____

What type of time-sharing do you have at this time? _____

Are you able to provide proof of time-sharing? ____ Yes ____ No

Are both parents willing to consent to treatment in the case of a shared parental responsibility?
____ Yes ____ No

Handedness: Right ____ Left ____ Both ____ Present Height ____ Present Weight ____

Is the child allergic to any drugs/foods? _____ Which ones? _____

Languages Spoken in Home: _____ Child's Primary Language: _____



Referred by: _____

How would you describe your child's current health: Excellent _____ Good _____ Poor _____

Explain: _____

Primary Care Physician/Pediatrician: _____ Phone: _____

Current medications? _____

Prescribed by? _____

Has your child ever engaged in therapy and/or testing before? Y / N

Date(s) & Outcome of Prior Treatment _____

Any history of suicidal/homicidal thoughts/attempts? _____

Current School: _____ Grade: _____ County: _____

Repeat any grades? _____ Yes _____ No If so, which grades and why _____

Favorite subjects in school? _____

Least favorite subjects in school? _____

What grades does your child usually receive in school? _____

Have there been any recent changes in the child's grades? ___ Yes ___ No

If yes, describe:

Has your child ever received special education services? _____ Yes ___ No

Explain _____



Has your child ever had or currently have an Individualized Education Plan (IEP)? ____ Yes ____ No

If yes, under which eligibility? _____

Describe your child's social support system. _____

Is your child able to complete activities of daily living (bathing, dressing, preparing meals, etc.)?

____ Yes ____ No Explain _____

Are there any special family, work, legal, medical, or stressor that I should be aware of? _____

Reason for Referral (*Please describe in detail the problems that are affecting your child and family*)

How long has this situation been present? _____

What have you tried to improve this situation? Does anything make it better? Or worse? _____

Have you sought help for these issues with other professionals? _____

If so, was it helpful? _____



Please list precipitating events and/or stressors leading to referral at this time.

What do you hope to learn as a result of attending therapy or completing this evaluation? In other words, what questions do you hope this evaluation will answer? _____

Are there any other circumstance that I have not asked about you that will be pertinent to understanding you or that you would like me to know about? _____



HANDBOOK SIGNATURE PAGE

I have read, understand, and agree to the conditions outlined in this handbook. I was provided with a copy of this handbook to keep for my records.

Client Name: _____

Client Signature: _____

Date: _____



Informed Consent

I have received a copy of this consent form, understand its content and will do my best to comply. I am aware that my clinician is available to answer any questions I may have. I understand the limits to confidentiality required by law. I understand that payment is due at the time services are rendered. I agree to pay the fee agreed upon based on the services I am receiving: psychological/psychoeducational evaluation, gifted testing, or therapy. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I understand that my session time is reserved specifically for me and/or my family members, and I am required to provide at least 24 hours notice prior to canceling. I am financially responsible for the full fee of any session not cancelled prior to the 24 hour notice. In the case of testing, a fee of \$75.00 will be charged for a session that is not cancelled within the 24 hours notice. My signature below indicates that I have read this client handbook and agree to its terms.

I hereby consent to psychotherapy/psychological or psychoeducational evaluation/gifted testing with Heather Kuhl, Psy.D., LMFT for my minor child(ren).

Client Signature

Date

Parent/Guardian Signature

Date

Clinician Signature, Degree, Title

Date