

Court Diversion/ Teen Alcohol Safety Intake

Associates in Psychotherapy &
Family Counseling
34 Patchen Rd.
So. Burlington, VT 05403

Katherine Job Zilboorg, LICSW, LADC, MAC
(802) 657-4208 ext. 2

(802) 658- 4208

Licensed Clinical Social Worker # 89-0000076
Licensed Alcohol & Drug Counselor # 000274

Demographic Information

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ May I leave messages for you at this number? Yes No

Cell Phone _____ May I leave messages for you at this number? Yes No

Work Phone _____ May I contact you at work during the day? Yes No

Social Security Number _____ - _____ - _____

Date of Birth ____/____/____ Gender: M F Marital Status: S M D W CU

Employment Status: Full-time Part-time Not Employed Student

I understand that Katherine Zilboorg LICSW, LADC, MAC does not accept insurance for the purpose of Teen Alcohol Safety Program or Court Diversion Assessments. Payment is expected at each session or sessions for the assessment. I understand that if I wish to continue in counseling after the assessment is completed, that Katherine Zilboorg does bill insurance for the psychotherapy sessions that occurs after the assessment. I understand that I will be responsible for the co-pay for those sessions.

Signature of Client _____ Date _____

Signature of Guardian _____ Date _____

SCHOOL & EXPECTED YEAR OF GRADUATION *[high school & college students]*

Employer's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Work Phone _____ ext. _____ May I contact you at work during the day? Yes No

Parent/guardian Information

Name _____
Street Address _____
City _____ State _____ Zip Code _____
Work Phone # _____ ext. _____ Home Phone # _____

In case of emergency contact the following person:

Name _____ Phone # _____
Name of Primary Care Physician _____ Phone # _____
Do we have your permission to contact your physician? Yes No

Current medications and amounts

Name of Medication	Dosage	Freq- uency	<u>Prescribed for</u>	<u>Side-effects experienced</u>

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Confidentiality:

Information disclosed in psychotherapy is confidential. This assurance is the cornerstone of trust between you and me. There may be times when you and I decide that it would be helpful for me to speak to someone else about your treatment, such as a physician. In these instances information may be disclosed if you give me permission in writing. The limits to confidentiality are the following:

- If you are using insurance, many insurance companies require treatment plans and diagnostic information before payment will be made.
- If, in my clinical judgment, I determine that you are in imminent danger of hurting yourself or another person and no safety plan can be established, I am required to alert others.
- I am legally required to report situations which involve abuse or neglect of children, adults who are incompetent, or adults who are physically or mentally disabled.

Appointments:

Appointments generally last between 45 and 50 minutes and are usually scheduled on a once a week or every other week basis. It is important that you arrive on time. If you are late, you will be unable to utilize your full appointment. I will wait 15 minutes for a late client, but will feel free to leave if I have not heard from you by then. My cancellation policy is as follows:

- You are requested to notify me by voice mail at least 24 hours in advance if you are unable to keep your scheduled appointment.
- Notification at least 24 hours in advance of your appointment will result in no charge for the appointment and you will not be billed.
- Notification less than 24 hours in advance of your appointment will result in a charge for the FULL FEE [\$100] which will be billed DIRECTLY TO THE CLIENT Payment will be expected by the next scheduled appointment. If your appointment time can be filled, however, there will be no charge for a late cancellation, so I appreciate you notifying me even if it is already a late cancellation, as I often can fill your time if I hear from you.

Agreement and Confirmation of Disclosure

I agree to pay fees at the time of service, unless other arrangements have been made, and I will abide by the policies regarding fees and cancellations. This agreement will remain in effect until services have terminated and all payments for rendered services have been made. A photocopy of this agreement is valid.

My signature(s) below indicates that I have received and had an opportunity to review the following materials from Katherine Job Zilboorg Licensed clinical social worker, Licensed Alcohol and Drug Abuse counselor, and master Addictions Counselor:

- 1) THE HIPAA REGULATIONS REGARDING CONFIDENTIALITY AND THE HANDLING OF RECORDS AND BILLING
- 2) THE DESCRIPTION OF UNPROFESSIONAL CONDUCT FOR SOCIAL WORKERS
- 3) A DISCLOSURE STATEMENT FROM KATHERINE JOB ZILBOORG AS MANDATED BY THE STATE OF VERMONT

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____