

# Intake

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

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

## **Associates in Psychotherapy & Family Counseling**

34 Patchen Rd.  
So. Burlington, VT 05403

(802) 658- 4208

For Office Use Only	DSM DX
Axis I a _____ I b _____ II _____ III _____ IV _____ V _____	
(GAF) _____ Intake Date _____ Referral Source _____	
Referral Phone _____	
GAF: Current: _____ Highest in Past Year: _____	
Clinicians Signature: _____	

## **The Purpose of Psychotherapy:**

Life can be difficult at times, and the way we relate to our lives can either promote growth or cause long-lasting consequences and suffering. My role in psychotherapy is to help you discover ways to mindfully cultivate those parts of you which promote growth, while becoming more aware of and reducing habitual patterns which cause continued suffering.

Psychotherapy is a collaborative process between you and your therapist. Together we will address personal, relational, mental health or substance abuse problems that you find important. As your therapist I will provide support, diagnostic information, feedback, a treatment plan, suggestions for readings/education, referrals as needed, and a space for your confidential disclosure. Please remember that psychotherapy can be challenging, rewarding, and sometimes a difficult process. This policy statement is intended to clarify financial and legal aspects of the process so that these aspects can be agreed upon and thus interfere as little as possible with the ongoing therapeutic process.

## **Demographic and EAP 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

## Employer Information

Employer's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

Primary Insurance Company Information

***This information is essential We also need a copy of the front and back of your insurance card.***

***Please bring this with you. Thanks.***

Your relationship to the insured: SELF SPOUSE CHILD OTHER(specify) \_\_\_\_\_

Date of Birth of Insured \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth of Insured \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Policy or Group # \_\_\_\_\_

Pre-certification Phone # (usually on back of insurance card) \_\_\_\_\_

### Secondary Insurance Company Information

Your relationship to the insured: SELF SPOUSE CHILD OTHER(specify) \_\_\_\_\_

Date of Birth of Insured \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Policy or Group # \_\_\_\_\_

Pre-certification Phone # (usually on back of insurance card) \_\_\_\_\_

IS AUTHORIZATION NECESSARY FOR THERAPY?    YES    NO

Authorization Date \_\_\_\_\_ Spoke with \_\_\_\_\_

Person who made authorization call \_\_\_\_\_

In case of emergency contact the following person:

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Do we have your permission to contact your physician?    Yes    No

Do we have your permission to contact your physician?    Yes    No

Fax # \_\_\_\_\_

Name of Psychiatrist or other Health Care Provider \_\_\_\_\_

Phone # \_\_\_\_\_

Do we have your permission to contact your physician?    Yes    No

Fax # \_\_\_\_\_

**Current medications and amounts**

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

Signature of Client or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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### **Methods and Duration of Treatment:**

The duration of psychotherapy varies based on your history, current circumstances, the issues we explore, and our mutually established goals for treatment. I use a variety of treatment methods including person-centered, cognitive-behavioral, psychodynamic and psycho-developmental. I have extensive experience in both mental health and substance issues and have treated both adults and adolescents. I have been supervised and trained in both pre and post graduate settings in Individual, Group, and Family Psychotherapy. I have experience working with a wide range of psychological issues including Depression, PostTraumatic Stress Disorder, Substance Abuse and Dependence, Anxiety, Dual Diagnosis with Substance Abuse and Relational Issues. I have been trained in brief therapy and longer-term models. Please feel free to ask me any questions you may have about my experience, training, the methods I use in treatment, or the expected duration of your treatment.

### **Fees and Payments:**

My fee is \$125 for a 45-50-minute session of individual, couple, or family psychotherapy. The length of the session may be determined by your managed care insurance coverage. Please feel free to talk to me about this. Co-Payment is expected at the time of service unless we have made other arrangements. In your first session we will agree upon your session fee and payment schedule.

Please feel free to discuss payment questions or problems with me if you anticipate any difficulties. Should collection action ever be necessary I reserve the right to use a collection agency and/or pursue traditional court assisted collection methods. If this is necessary you will be responsible for my attorney fees and court costs.

### **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: \_\_\_\_\_

Signature #2 (if needed): \_\_\_\_\_