Barbara Kleinman, MSW, LICSW
525 Hercules Drive, Suite 1A, Colchester, VT 05446
802-264-5333 x 114, fax 802-264-5338

New Client Packet

Client's Last Name: _____ First Name: _____

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____Cell:_____ DOB:: _____

Email:_____

Emergency Contact and Telephone Number: _____

Marital Status: _____Referred by: _____

Primary Care Physician:_____

Occupation/Employer:_____

Insurance Information

Name of Responsible Party (if other than self): _____DOB_____

Address: _____ City: _____ Zip: _____

Phone: _____Relationship: _____Employer:_____

Insurance I: _____ Co-pay Amount: _____

Mailing Address: _____

Deductible/Co-Pay Amount:_____

Subscriber Name: _____Relationship: _____DOB:_____

Certificate/ID#: _____ Group#: _____

Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____

Secondary Insurance

Insurance II: _____ Co-pay Amount: _____

Insurance Mailing Address: _____

Subscriber Name: _____Relationship: _____DOB:_____

Certificate/ID#: _____ Group#: _____

Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____.

Is condition related to employment? _____

Auto Accident? _____

Other Accident? _____

By signing below you consent to psychotherapy with Barbara Kleinman, LICSW and you authorize the release of any medical/mental health information or personal information on this form to your insurance company to process this claim.

Signature: _____ Date: _____

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____
_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no
( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly
( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.

Barbara Kleinman, MSW, LICSW
525 Hercules Drive, Suite 1A, Colchester, VT 05446
802-264-5333 x 114, fax 802-264-5338

Professional Disclosure and Policies

The state of Vermont requires Licensed Clinical Social Workers to disclose information about themselves, and ways to deal with disputes and disagreements to their clients. This document also represents an agreement between us. Your signature at the end of this document indicates your agreement with these policies.

Qualifications and Experience

I am licensed by the state of Vermont:

License #: 0089-0000957 Licensed Independent Clinical Social Worker

My graduate education was conducted at the University of Vermont, Department of Social Work:

MSW (1998) Social Work with Children and Families

My areas of clinical concentration include family therapy, parenting issues, trauma, divorce, grief and loss, depression, anxiety, PTSD, life changes, chronic illness. I work with adults, families, couples, groups and primary care physicians. I am also trained as an EMDR (Eye movement Desensitization and Reprocessing) therapist.

My professional experience includes work with children and their families through the Department of Children and Families (DCF) as a social worker and social work supervisor from 1991 – 2011.

After Hours Availability

Please direct all non-emergency calls to my office voice mail at 802.264.5333 x 114 during the week and after hours. Leave messages about cancellations, requests for services, etc. I usually return calls with 24-48 hours. If you have a life-threatening emergency, risk of suicide or bodily harm to yourself or another person) call 911.

If you have a clinical emergency, (i.e. extreme emotional/behavioral situation) call 802.264.5333 x 114. I will return your call as soon as possible. If I am not immediately available to respond to an emergency, call the community services in your area.

Chittenden County Crisis

First Call for Children and Families……..802-488-7777
Adult Crisis……..802-488-6400
Alcohol Crisis Team……..802-488-6425
Domestic Abuse Hotline……..802-659-1996
Department for Children and Families..802-863-7370

Franklin County Crisis……..802-524-6554
Addison County Crisis……1-800-489-7273 or 802-388-7641

People living outside Chittenden, Franklin and Addison counties should consult their local listings for emergency service numbers.

Disputes or Complaints

Please discuss any concerns you might have regarding your counseling or related issues directly with me at any time. I will make every reasonable effort to resolve disputes or conflicts in a satisfactory manner.

The practice of Clinical Social Work is governed by state law. You have the right to lodge a complaint with the Vermont Secretary of State in the following manner:

by calling 802-828-2367 and/or

by writing to the Vermont Secretary of State, Office of Professional Regulation, Board of Allied Mental Health Practitioners, Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, Vermont 05609-1106.

Unprofessional Conduct

The Vermont State Statute§3210 Regarding Unprofessional Conduct states: (a) The following conduct and the conduct set forth in section 129a of Title 3 by a licensed social worker constitutes unprofessional conduct. When that conduct is by an applicant or a person who later becomes an applicant, it may constitute grounds for a denial of a license:

1. *Failing to use a correct title in a professional activity;*
2. Conduct which evidences unfitness to practice clinical social work;
3. Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the licensee has had a professional relationship within the previous two years;
4. Harassing, intimidating, or abusing a client or patient;
5. Practicing outside or beyond a clinical social worker's area of training, experience, or competence without appropriate supervision;
6. Engaging in conflicts of interest that interfere with the exercise of the clinical social worker's professional discretion and impartial judgment;
7. Failing to inform a client when a real or potential conflict of interest arises and to take reasonable steps to resolve the issue in a manner that makes the client's interest primary and protects the client's interest to the greatest extent possible;
8. Taking unfair advantage of any professional relationship or exploiting others to further the clinical social worker's personal, religious, political, or business interests;

9. Engaging in dual or multiple relationships with a client or former client in which there is a risk of exploitation or potential harm to the client;
10. Failing to take steps to protect a client and to set clear, appropriate and culturally sensitive boundaries in instances where dual or multiple relationships are unavoidable;
11. Failing to clarify with all parties which individuals will be considered clients and the nature of the clinical social worker's professional obligations to the various individuals who are receiving services, when a clinical social worker provides services to two or more people who have a spousal, familial or other relationship with each other;
12. Failing to clarify the clinical social worker's role with the parties involved and to take appropriate action to minimize and conflicts of interest, when the clinical social worker anticipates a conflict of interest among the individuals receiving services or anticipates having to perform in conflicting roles such as testifying in a child custody dispute or divorce proceedings involving clients.

(a)After hearing, and upon a finding of unprofessional conduct, an administrative hearing officer may take disciplinary action against a licensed clinical social worker or applicant.

As set forth in Title 3: Executive, Chapter 5:Professional regulation, Sub-chapter 3: Professional Regulation, 3 VSA 129 a,

(a) in addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. Any one of the following items, or combination of items, whether or not the conduct at issue was committed within or outside the state, shall constitute unprofessional conduct:

1. Fraudulent or deceptive procurement or use of license,
2. Advertising that is intended or has a tendency to deceive;
3. Failing to comply with the provisions of federal or state statutes or rules governing the practice of the profession,
4. Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.
5. Practicing the profession when medically or psychologically unfit to do so,
6. Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials, to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licenses or registered as required by the laws of that person's profession,
7. Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper records or reports,
8. Failing to make available promptly to a person using professional health care services, that person's representative, or succeeding helth care professional or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licenses practitioner, or failing to notify patients or clients how to obtain their records when a practice closes,
9. Failing to retain client records for a period of seven years, unless laws specific to the profession allow for a shorter retention period. When other laws or agency

rules require retention for a longer period of time, the longer retention period shall apply.

10. Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession,

11. Failing to report to the office a conviction of a felony or any offense related to the practice of the profession in a Vermont District Court, a Vermont superior Court, a federal court, or a court outside Vermont within 30 days,

12. Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party.

13. Performing treatments or providing services which the licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice,

14. Failing to report to the office within 30 days a change of name or address,

15. Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

16.(A) Impeding an investigation under this chapter or unreasonably failing to reply, cooperate, or produce lawfully requested records in relation to such investigation. (B) The patient privilege set forth in 12 VSA 1612 shall not bar the licensee's obligations under this subdivision (16).

17. Advertising, promoting, or recommending a therapy or treatment in a manner tending to deceive the public or to suggest a degree of reliability or efficacy unsupported by competent evidence and professional judgement.

18. Promotion by a treatment provider of the sale of drugs, devices, appliances, or goods provided for a patient or client in such a manner as to exploit the patient or client for the financial gain of the treatment provider, or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

19. Willful misrepresentation in treatments or therapies.

20. Offering, undertaking, or agreeing to cure or treat disease or disorder by a secret method, procedure, treatment, or medicine.

21. Permitting one's name or license to be used by a person, group, or corporation when not actually in charge or responsible for the professional services provided.

22. Prescribing, selling, administering, distributing, ordering, or dispensing any drug legally classified as a controlled substance for he licensee's own use or to an immediate family member as defined by rule.

23. For any professional with prescribing authority, signing a blank or undated prescription form or negligently failing to secure electronic means of prescribing.

24.For any mental health care provider, use of conversion therapy as defined in 18 VSA 8351 on a client younger than 18 years of age.
Subdivision (a)(25) effective July 1, 2019.

25. For providers of clinical care to patients, failing to have in place a plan for responsible disposition of patient health records in the event the licensee should become incapacitated or un

(b) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:
    1. Performance of unsafe or unacceptable patient or client care; or
    2. Failure to conform to the essential standards of acceptable or prevailing practice.
(c) The burden of proof in a disciplinary action shall be on the State to show by a preponderance of the evidence that the person has engged in unprofessional conduct.
(d) After hearing and upon a finding of unprofessional conduct, a board or an administrative law officer may take disciplinary action against a licensee…including imposing an administrative penalty not to exceed $1000 for each unprofessional conduct violation…
(e) In the case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern.

Agreements of Financial Responsibility for Clients

I, client/guardian, agree to contact my insurance carrier to review available coverage and to be fully responsible for all charges that are not covered by my insurance. I understand that such charges include deductibles, co-payments, as well as fees for telephone consultation, report preparation, school meetings/consultations, late cancellations or missed sessions, and/or sessions contracted for beyond those certified by my managed care system. I understand that my managed care company or insurance company may require a review of clinical information, or other information, to verify benefits and assist in claims in order to pay for services, and I give permission to Barbara Kleinman, LICSW and/or the clinician's billing agent to provide such information.

I hereby authorize my insurance benefits to be paid directly to Barbara Kleinman, LICSW, **and acknowledge that I am financially responsible for any unpaid balance. I understand that a full 24 hours notice is required for cancellation of appointments. I understand that a fee of $50.00 will be charged directly to me for missed appointments for which I have not given a full 24-hour notification. I understand that this fee must be paid by me and that my insurance will not cover it.** Clients with primary or secondary Medicaid insurance cannot be charged this fee. If you are ill, there is a natural disaster, or weather would not permit safe transportation to the appointment, this fee will be waived.

Informed Consent

Confidentiality

Your psychotherapy services and records are confidential, however, limits to this confidentiality do exist and include: minors or other persons with a legal guardian, imminent danger to self (e.g suicide risk), danger to others, suspicion of abuse or neglect to a child or vulnerable adult, or/and under court order. If you have signed a release with an insurer, the insurer may request such information as diagnosis, treatment plan, and general course of treatment. However, it is important to note that some insurers may request release of more detailed or sensitive information. Please discuss with me any concerns you may have about such disclosure.

I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The consultant is also legally bound to keep the information confidential.

Treatment

I understand that my participation in therapy is completely voluntary, and that I may terminate treatment at any time. The goals of my treatment have been agreed upon with my provider. I understand that I may negotiate changes in these goals at any time.

Client Disclosure and Consent Confirmation

My signature acknowledges that I have been given a copy of the professional qualifications and experience of Barbara Kleinman, MSW, LICSW, a statement of hours of availability, as well as a listing of actions that constitute unprofessional conduct according to Vermont Statutes. I have also been informed of the method for making a consumer inquiry for filing a complaint with the Office of Professional Regulation. In addition I have reviewed copies of an informed consent statement, and HIPPA privacy practices.

Unexpected Therapist Absence

In the event of my unplanned absence from practice, whether due to family emergency, injury, illness or death, I maintain a professional Will with instructions for an Executor, or Secondary Executor, to inform you of my status and, if you choose, to help you transition to another therapist, including forwarding records to the selected therapist or releasing records, to you. By signing this form, you authorize the Executor to access your treatment and financial records **only** in accordance with the terms of my Professional Will, and **only** in the event that I experience such an event. Additionally, you are authorizing my executors to conduct this business without obtaining a new consent from you.

Agreement

My signature below represents my understanding of, and agreement to the policies contained in this document.

Client Date

Clinician signature Date

Barbara Kleinman MSW, LICSW

Notice of Privacy Practices

This notice will tell you about the ways in which I use and disclose health information about you. It also describes your rights and certain obligations I have regarding the use and disclosure of health information.

I am required by law to:
Make sure that health information that identifies you is kept private;
Give you this notice of my legal duties and privacy practices with respect to health information about you; and
Follow the terms and notices that are currently in effect.

As stated above, your mental health services and records are confidential, however, limits to this confidentiality do exist. I am a ***mandated reporter*** and am under legal obligation to report the following to authorities:

Danger to yourself or to others;
Actual or suspected child abuse or neglect;
Actual or suspected abuse or neglect of persons with a disability, or the elderly.

There are other situations when I may use or disclose health information about you without your prior authorization, such as:

Emergencies
To respond to a court-ordered subpoena to testify or to provide records;
Situations that directly affect the health and safety of others;
Health oversight audits or inspections;
Public health purposes;
To prevent a serious threat to your health or the health and safety of the public or another person;
When a child under the age of 16 is a victim of a crime;
Legal proceedings or law enforcement;
Workers' compensation purposes;
Firearm related injuries;
National Security.

In any other situation not covered by this notice, I will ask for your written authorization before using or disclosing health information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying me in writing of your decision.

If you have signed a release with your insurer, that insurer may request such information as diagnosis, treatment plan, and general course of treatment. It is important to note that some insurers may request release of more detailed or sensitive information. Please discuss with me any concerns you may have about disclosures.

Barbara Kleinman MSW, LICSW

Notice of Privacy Practices

What is HIPPA?
The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed to me, in any form, whether electronically, on paper, or orally, are kept properly confidential. For Clinical Social Workers, this requires the same practice of confidentiality that has been required by our profession prior to HIPPA. In general, the HIPPA ACT gives you, the client, significant new rights to understand and control how your health care information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, I have prepared this explanation of how I will maintain the privacy of your health information and how I may use and disclose your health information.

Your rights regarding health information about you:
In most cases, you have the right to look at or get a copy of the information that I keep in your record. Please put your request in writing. If you request copies, I may charge a fee for the cost of copying, mailing or other related supplies. If I do not agree to your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that I correct your records by submitting a request in writing that provides your reason for requesting the amendment. I could deny your request to amend a record if the information was not created by me; if it is not part of the medical information maintained by me; or if I determine that the record is accurate. You may appeal in writing a decision by me not to amend the record.

You have the right to a list of those instances where I have disclosed health information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6 year period. You may receive the list in paper or electronic form.

You have the right to request that health information about you be communicated to you in a confidential manner. You may also request in writing that I not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized

by you, when required by law, or in an emergency. I will consider your request, but am not legally required to accept it.

Complaints:
If you are concerned that your privacy rights may have been violated, you can file a complaint with me or with the:

Office for Civil Rights
US Dept of Health and Human Services
Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, MA 02203
Voice phone (617) 565-1340
FAX (617) 565-3809
Under no circumstances will you be penalized or retaliated against for filing a complaint.

Revised June 2019