Katherine Gibbs, Psy.D.
P.O. Box 775432, 1955 Bridge Lane, Suite 1500
Steamboat Springs, CO 80477
Office: (970) 879-7540 Fax: (970) 870-6682

Intake Form

Responsible Party:_____DOB:_____Social Security #_____

Client Name:_____DOB:_____Social Security #_____

Emergency Contact: Name_____Mobile Phone:_____

Your Street Address:_____Mobile Phone:_____

Mailing Address:_____Home Phone:_____

City:_____State:__Zip:_____ Work Phone:_____

Email Address:_____

Insurance Company Name:_____Phone:_____

Insurance Policy/Group # or Medicaid #:_____

Insurance Address:_____State:_City:_____Zip:__

Employer:_____

Annual Household Income:_____

People in Household:_____Relationship:_____Age:_____

Please note any medical concerns for the above individuals on the back of this form

I understand the fee for out-patient psychotherapy is dictated by my insurance company. If my insurance has a set reimbursement rate, this fee will be adjusted to meet HMO or PPO contracted rates. Once a release of information is signed, case management calls or meetings longer than 10 minutes (with teachers, physicians, relatives, etc.) will be charged based on the time spent. Payment is due at the time services are rendered unless other payment arrangements are made. Twenty-four hour notice is required for cancelled sessions. If adequate notice is not given, I am aware that I may be charged for the missed session. If I do not contact Dr Gibbs to arrange my next session within 2 months, my file will be closed and I will no longer be considered an active client in her caseload. If that is the case, I will need to re-contact Dr Gibbs for an intake session to re-activate my file and return to therapy.

Dr Gibbs does not have a presence on social media and will not respond to information sent through social media platforms.

I understand that psychotherapy services are confidential within the guidelines of the law. I have read and understand the mandatory disclosure information form Dr. Gibbs has provided for me. She is a mandatory reporter of suspected child abuse, and suicidal or homicidal potential.

If a third party payer (ie insurance company, managed care agency, etc.) is involved in paying for my psychotherapy fees, I give permission for Dr. Gibbs and her office coordinator to contact the appropriate company to discuss financial and therapeutic arrangements and to have payments paid directly to Dr. Gibbs. I am aware that Dr. Gibbs' office coordinator will also respect my confidentiality while processing my claims.

I am aware that my fee for psychotherapy sessions is: $_____

Client/Guardian Signature:_____Date:_____