ONLY TELEHEALTH
9040 Town Center Parkway, Lakewood Ranch, Fl 34202
(845) 364-9226, Fax: (845) 512-5244
Claudia@vicalexbehavioralhelath.com

INTAKE FORM

Please provide the following information.
All information you provide here is protected as confidential information.

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

Lawyer's name: _____

Court date (if applicable): _____

Name of spouse (if applicable): _____

Marriage date (if applicable): _____

Name of parent (if your parent has an immigration case): _____

Name of children (if applicable):

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Name: _____

Birth Date: _____ Age: _____ Gender: _____

Name: _____

Birth Date: _____ Age: _____ Gender: _____

PERSONAL HISTORY

When and where the client was born: _____

How they were raised and by whom: _____

Overview of the family of origin and family dynamics:

Discuss if any abuse or domestic violence in family or origin:

Adolescence & early adulthood:

Current relationship with the family of origin:

Previous marriages/children (if applicable)

How marriage ended and current contact with children

Major life changes/losses

Trauma history (including any abuse, domestic violence outside the family of origin)

Criminal history

Any rehabilitation or important lesson learned

EDUCATION AND EMPLOYMENT HISTORY

Highest level of education completed and where

If college attended

- Date graduated: _____
- Degree obtained: _____
- Major field of study: _____

Plans to continue education in future

If currently enrolled, give information about courses and field of study

Any education/certifications required for work

A concise summary of employment prior to the current job.

Ex/ Past work included positions with X, Y, and Z, in the field of ……

Describe current employment

- Job title: _____
- Main responsibilities: _____

- Prospects for future growth/employment: _____

_____

- Client's current job satisfaction and/or career goals: _____

_____

Prior or current military service

- Branch: _____
- Length of service: _____
- Any awards or commendations: _____

MARRIAGE AND FAMILY LIFE (FOR SPOUSAL CASES)

Full name of spouse: _____

When and where they met: _____

Description of their courtship: _____

_____

Dates of marriage: _____

Communication styles, including conflict resolution: _____

_____

Challenges they have faced together: _____

_____

Activities they enjoy together: _____

_____

_____

Living situation (where do they live and with whom): _____

_____

_____

Other important family members: _____

Community involvement: _____

Religious life (if applicable): _____

If they have children (including step-children)

- Name of children and dates of birth: _____

- Dates of children's birth: _____
- School information (include relevant educational reports): _____

  _____

  _____
- Medical information if any health problems: _____

  _____
- Psychological information (if they are in treatment, etc):_____

  _____

  _____

FAMILY LIFE (FOR CHILDREN OR PARENT CASES)

Full name of the relative: _____

Living situation (where do they live and with whom) _____

_____

Description of their relationship _____

_____

_____

Emotional bonds: _____

Activities they enjoy together _____

Needs that the family member provides for the client _____

Other important family members _____

_____

Community involvement _____

_____

Religious life (if applicable) _____

_____

PHYSICAL AND MENTAL HEALTH

Physical health

Overview of physical health: _____

Past illnesses and surgeries: _____

Current medical conditions _____

_____

_____

Medications taken: _____

_____

_____

Specialist seen by the client: _____

_____

_____

Accidents/head injuries/loss of consciousness: _____

_____

Refer to relevant medical records _____

_____

Mental health

History of symptoms or diagnosis _____

_____

_____

Any disorders currently in remission _____

_____

Previous therapy or hospitalization _____

_____

Alcohol/drug use (past & current) _____

_____

Vicalex
Behavioral Health & Immigration Services PA

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INFORMED CONSENT FOR PSYCHOSOCIAL ASSESSMENT

This document is a disclosure of certain information about the psychosocial assessment process. This form will give you information about the assessment process. It details certain rights and responsibilities that you have in this process and gives you information about me.

The assessment consists of a comprehensive clinical interview, including the use of psychological screening tools. In addition, it may be necessary to review other related materials such as legal, medical, psychological, and educational records, etc. collateral information may be needed from physicians, school records, and/or current/former psychotherapists may be necessary.

This assessment aimsto obtain information about your past and current personal and psychological status in connection with your immigration case. This consent is for the sole purpose of facilitating an immigration psychosocial assessment and is not intended for psychotherapy.

Claudia Olave-Guillermo, MA, MSSW, LCSW-R is not responsible for the outcome of any immigration proceeding in which this psychosocial assessment is submitted. **Claudia Olave- Guillermo, MA, MSSW, LCSW-R** takes no responsibility for any information written in this assessment that differs from the information that you may present in your testimony, declaration, affidavit, or any other communication.

I reserve the right to cancel this contract at any time, for any reason, without prior notification in cases including, but not limited to, non-payment or in the case of malingering.

Your participation in this assessment is voluntary. **Claudia Olave-Guillermo, MA, MSSW, LCSW-R** will not conduct the assessment without your signature on this document. You have the right to stop the assessment at any time. If, at any time, you have a question about any aspect of the assessment, please feel free to ask me. In addition, if at any time you need a break from the assessment, please let me know.

_____
Initial

QUALIFICATIONS

I have been providing psychotherapy to children, adolescents, and adults and conducting psychosocial assessments since 1999. I have a Master of Science in Social Work from Columbia University. I am licensed in New York State, license# R071579-1, in the State of Florida, license #SW19619, in the State of Georgia, license #

CANCELLATION POLICY

I request that you provide me a two (2) day notice for the cancellation or rescheduling of an appointment by leaving a message at (845) 364-9226. If you do not cancel a session two (2) days in advance and do not attend, you will be charged an additional fee of $200 for a one-hour appointment or $400 for a two-hour appointment.

The fee for a missed session is due at the time of the next scheduled appointment. There are some exceptions to this policy (e.g., severe illness, family death), which will be evaluated case-by-case.

_____
Initial

RISKS AND BENEFITS

Although psychosocial assessments may provide some therapeutic benefits, they are not therapy. Individuals may benefit from ongoing psychotherapy. If I determine that you may benefit from ongoing therapy, I recommend searching for a therapist on www.pscyhologytoday.com.

Every effort will be made to minimize any discomfort that you may experience during the assessment. Nonetheless, you may experience distress and difficulties pertaining to the material you are relating to. As this is a collaborative process, we may decide that a different service or another therapist would better serve you.

EMERGENCIES

If you have an emergency between our sessions and need immediate help, I recommend that you call 911 or go to your nearest emergency room.

CONFIDENTIALITY

Your confidentiality is extremely important to me. All information provided during the assessment will be held confidential, except for the written psychosocial evaluation, which will be given to you and your attorney. While your privacy is paramount, so is your safety and the safety of others who may be in danger. There are several situations in which I may be legally obligated to break confidentiality:

- If you express intent to harm yourself seriously
- If you threaten serious bodily harm to another person/s
- If there is suspicion or evidence of abuse or neglect of a child, elder, or vulnerable person
- If compelled by a court order

In any of the above situations, you and I will first discuss and attempt to come to an agreement on how to proceed. If we cannot do so safely and legally, I will do so independently, and I will take further measures without your permission that are provided to me by law.

_____
Initial

If your attorney has requested this assessment, with your written permission, they will receive a copy of the report and will determine how it will be used and who has access to it. Information regarding this assessment may be disclosed to a judge, attorneys, USCIS (the United States Citizen and Immigration Services), and other court and agency personnel involved in this case.

Once a decision has been made to use the report in a legal proceeding, the report and any information pertaining to it may be admissible into evidence and any other information that was provided concerning your mental health and functioning. If you have any concerns about the use or distribution of this report, you should discuss these issues carefully with your attorney.

Additionally, I will release information to others at your request if you have signed a release of information form for an individual or agency.

FEES

The fee for a psychosocial evaluation is $ 1,300. If additional family members need to be included in the same report, $ 650.00 will be charged for each additional member.

For individual psychological evaluations for members of the same family, you will be provided with a 20% discount for each evaluation, with a total of $1,040 for the additional family member and 20%, consequently.

The fee includes a structured interview/s, psychological screening, report writing, your lawyer and your review, and the final report signing. The report will be prepared within 4 weeks after the last evaluation meeting.

_____
Initial

The expedited fee for a psychosocial evaluation is $ 2,100 if needed in 5 days. In the case of an expedited report, the psychosocial evaluation will be complete no more than 5 business days from the time of our last meeting.

_____
Initial

Payment is due at the time of service.

COURT TESTIMONY

The fee for a court appearance is $200 an hour, including travel time and time waiting for the hearing. If I am required to attend a court appearance, **the payment retainer of $ 600 needs to be paid five days prior.**

I have read and discussed the above policies with **Claudia Olave-Guillermo, MA, MSSW, LCSW-R**. I was given the opportunity to ask questions, they were answered to my satisfaction, and I understand my rights and responsibilities as a client. I give consent to participate in a psychosocial assessment within the above guidelines. I have been given a copy of this form for my records.

_____ _____
Client Signature Date

_____ _____
Claudia Olave-Guillermo, MA, MSSW, LCSW-R Date
NPI 1568463255

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Authorization for Electronic Communication

As a convenience to me, I hereby request that **Vicalex Behavioral Health & Immigration Services PA** communicate with me regarding my treatment by **Claudia Olave-Guillermo, MA, MSSW, LCSW-R,** via electronic communications (e-mail or text message). I understand that this means **Vicalex Behavioral Health & Immigration Services PA** will transmit appointment reminders via text messages if marked "yes" on the registration form.

My protected health information, such as information about my diagnosis, medications, progress, and other individually identifiable information about my treatment, will be transmitted via a HIPAA Policy-Based Encryption Service, which will encrypt the email to me via electronic communication. To access the encrypted email, I will need to activate a free account as per the instructions of the encrypted email.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted, or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will be encrypted, except for the text message appointment reminders. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, **Vicalex Behavioral Health & Immigration Services PA** shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by **Claudia Olave-Guillermo, MA, MSSW, LCSW-R** to me.

After being provided notice of the risks inherent in the use of electronic communications, I hereby expressly authorize **Vicalex Behavioral Health & Immigration Services PA** to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from **Claudia Olave-Guillermo, MA, MSSW, LCSW-R**, I may

revoke this authorization by providing written notice to **Vicalex Behavioral Health & Immigration Services PA** at 9040 Town Center Parkway, Lakewood Ranch, Fl 34202 or fax at **845-512-5244**.

I agree that **Claudia Olave-Guillermo, MA, MSSW, LCSW-R,** may communicate with me electronically unless and until I revoke this authorization by submitting a notice to **Vicalex Behavioral Health PA** in writing. This authorization does not allow for the electronic transmission of my protected health information to third parties. I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize electronically transmitting my protected health information as described above.

_____ _____

Patient Name Date

_____ _____

Signature of Patient Date

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Telemental Health Informed Consent

I _____, (name of client), hereby consent to participate in telemental health with **Claudia Olave-Guillermo, MA, MSSW, LCSW-R,** as part of my psychotherapy due to COVID-19. I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or another electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks and consequences associated with telemental health, including but not limited to disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I will call you to continue the session.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person whom I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

And my emergency contact person's name, address, phone:_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

Behavioral Health PA
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Consent to Disclosure of Information and Records

I, _____, Date of Birth _____ hereby authorize **Claudia Olave-Guillermo, MA, MSSW, LCSW-R** to release my immigration assessment report. This information is to be given to: _____

(Lawyer and phone number)

for the following purpose, use, or need:

- ☐ Provision of information to other professionals
- ☐ Other

The following information will be disclosed:

- ☐ General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- ☐ Verbal Exchange of PHI

I understand that I may withdraw this authorization at any time. Revocation of this authorization will not affect any information already released. I, at this moment, certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until treatment is terminated.

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of [ ]'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact [ ].

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**