LEIGH ELLEN RODRIGUEZ,LPC
RODRIGUEZ COUNSELING SERVICES, PLC

397 LITTLE NECK ROAD, STE 230
VIRGINIA BEACH, VIRGINIA 23452
LEIGHELLENRODRIGUEZLPC@GMAIL.COM
757.716.8221

CLIENT INTAKE FORM

CLIENT INFO

Date of Birth: ___/___/___ Age: _____ M / F

Name:_____

Address:_____

City:_____

Home:_____ Cell: _____

Work:_____ Other:_____

On what number may I leave a confidential message:

____ Home ____ Cell ____ Other

How were you referred to me? _____

EMPLOYER & STATUS

Employer: _____

I am: ___self-employed ___unemployed ___retired

I am: ___single ___married ___divorced

How many people live in your household? _____

Religion as a child: _____

Religion currently: _____

Counseling history:

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications: _____

SYMPTOM ASSESSMENT

I AM EXPERIENCING:	NEVER	SELDOM	OFTEN	ALWAYS	HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					

Phobias: unsual fears about specific things

Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations

Recurring, distressing thoughts about trauma

"Flashbacks" as if reliving the traumatic event

Avoiding people/places associated with trauma

Nightmares about traumatic experience

I AM FEELING:	NEVER	SELDOM	OFTEN	ALWAYS	HOW LONG?
Decreased interest in pleasurable activities					
Social isolation, Loneliness					
Suicidal Thoughts					
Non-suicidal self-injurious thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE:	NEVER	SELDOM	OFTEN	ALWAYS	HOW LONG?
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE:	NEVER	SELDOM	OFTEN	ALWAYS	HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					

Been hearing voices when alone

Problems with my speech

I Have:	Never	Seldom	Often	Always	How long?
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequences					
Been physically harming myself					
Been violent toward others					

I Use the Following:	Never	Seldom	Often	Always	How long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

My Eating Involves:	Never	Seldom	Often	Always	How long?
Restriction of food consumption					
Bingeing and/or Purging					
Binge Eating					
A lot of weight loss or gain					
Excessive exercise in response to food consumption					

Employment & Self-Care:	Never	Seldom	Often	Always	How long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					

Research has shown that heredity plays a role in many disorders. Please take time to think of your various blood related relatives.

My Family Has A History Of:	Yes	No	Who
Alcoholism and/or drug dependence			
Anxiety			
Depression			
Bipolar Disorder or distinct changes in behavior or mood			
Eating disorders			
Phobias			
Suicidal behavior			

Please note any other medical or emotional problems with similar symptoms to yourself.

What is the Major concern that led you here today?

What do you consider your strengths?

What do you consider your weaknesses?

What do you hope to gain from therapy?

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES REGARDING THE ABOVE INFORMATION.

SIGNATURE: _____ DATE: _____

LEIGH ELLEN RODRIGUEZ, Ed, S, LPC

CLIENT RIGHTS AND RESPONSIBILITIES

ABOUT YOUR COUNSELOR

EDUCATION AND EXPERIENCE

I am a Licensed Professional Counselor in Virginia, License number 0701002702. I received my Master's Degree in Mental Health Counseling and Educational Specialist from James Madison University after completing my undergraduate studies from the University of Virginia. I have been providing clinical services since 1995 in a variety of settings, including JMU's student counseling center, private practice, and have provided outpatient and crisis counseling at a community services board. The majority of my clinical experience is with adolescents and adults. I am EMDRIA certified in Levels 1 and 2 EMDR and am an EMDRIA approved Consultant in EMDR. Additionally I am a Certified Clinical Trauma Professional. I am a Board Approved Supervisor for Residents in Counseling for the State of Virginia.

COUNSELING PROCESS _____ (initial)

PERSONAL METHOD OF TREATMENT

My method of treatment combines various interpersonal process, family systems, cognitive-behavioral, trauma-informed, and experiential therapy ideas. I take a positive approach to people and problems, believing that people are resilient, and have a tremendous ability to address their life situations. I often use a therapeutic approach called EMDR to assist in doing this, which is designed to help resolve past distressing events. It is my role as a therapist to help you understand the dynamics of your situation and to help you use you particular strengths to address issues and concerns.

As a Christian, my beliefs impact and shape the work I do with clients. I believe my clients are made in the image of God and are worthy of honor and respect. I regularly pray for each client by name. I realize that you may not share my beliefs and it is my hope to be of help to you regardless of your religious orientations or personal beliefs. I think you will find my approach non-judgmental and you will feel comfortable wherever you are in your spiritual journey. If your spiritual beliefs differ from mine and this is a concern for you, please discuss this with me at the beginning of therapy.

GOALS, RISKS, BENEFITS

There is always a risk of psychological side effects with psychotherapy. Sometimes symptoms worsen before they get better. You can expect to experience some emotional and relational discomfort as we attempt to resolve issues and change behavioral patterns. Old ways of thinking, acting, and feeling are likely to come under duress as we work toward your goals. Our goal is to confront issues and emotions, and with time, to work through them together. This will be done at your pace.

LENGTH

Length of treatment is very difficult to predict. Each individual has unique strengths and weaknesses, and each problem is different from the next. My goal is that each client will finish in a timely manner, without unnecessary waste of time or money. Together, we will determine your goals for therapy and how often you should come.

TERMINATION

Termination is a part of the process of counseling; therefore, it must conclude in a normal session. You may choose to withdraw from participation at any time, although I do request you give at least one-week notice of termination to allow for closure.

RECORDS AND CONFIDENTIALITY _____ (INITIAL)

Confidentiality is a vital element of trust in the therapeutic relationship. I will be keeping a record of health care services provided to you. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. There are laws, under HIPAA, regarding your rights for records and confidentiality. I comply with all HIPAA regulations. Some situations where the law allows disclosure of some information without the client's authorization are: to other health care providers, to public health authorities, and to any other person requiring information for an audit, quality assurance, peer review, or administrative, legal, financial or actuarial services to the health care provider.

The law requires disclosure of information pertaining to suspected child, dependent adult and elder abuse, inability to care for one's basic needs for food, clothing or shelter and threatened harm to oneself or others. This is called "Duty to Warn" and will be enacted upon by my reporting to the

appropriate authorities, which includes both governmental/emergency services. If I am aware that you are HIV positive, I may be required by state law to report your HIV status to health authorities if you are recklessly behaving in ways that could spread HIV or if you require help in notifying past partners of their possible exposure to HIV. Courts may also subpoena records.

When a couple or family enters into therapy, information shared with me privately by one family member may be used at my discretion in work with the couple or family. If you choose to have a family member participate in therapy, either individually or jointly, you voluntarily waive the right to confidentiality (i.e. secrets) with them. I will require that a release of information consent form be obtained.While I am bound by ethics and law to protect confidentiality, others involved in your treatment (as in family, couples or group therapy) are bound only by their word and trust.

LIMITATIONS OF CONFIDENTIALITY _____ (INITIAL)
It is understood and agreed that the information you disclose in counseling (whether written or verbal) is of a confidential nature and ethically cannot be disclosed, without written consent with the following exceptions:

THREATS TO HARM SELF OR OTHERS

If you express a serious threat, or intent to kill or seriously injure yourself and/or an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm including notifying the appropriate person, agency or civil authorities of any threats of harm that you may attempt or desire to do to yourself or to others.

SUSPICION OF CHILD/ELDER ABUSE AND PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

If I have reasonable cause to believe or suspect that an elder or a child is in need of protective services I am mandated by law to report child/elder abuse or suspicion of child/elder abuse of any type to the proper authorities.

Mental Health Care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

MINORS/GUARDIANSHIP
Parents or legal guardians of non-emancipated minors have the right to access the client's records.

INSURANCE PROVIDERS (WHEN APPLICABLE)

Insurance companies and other third party payers are given information they request regarding services to clients. Information that may be requested includes, but is not limited to, types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

BILLING ADMINISTRATOR

You understand that I use BC Morgan Credentialing and Consulting Services, LLC for billing purposes and authorize communication with them for such purposes.

NECESSITY OF SUPERVISION AND CONSULTATION

It is in your best interest that I seek professional supervision/consultation when needed from other counseling professionals.At times I will consult with other licensed therapists; however, all identifying information will remain protected. I regularly consult with Rachel Harner, LPC and Kim Small, LPC.

EMERGENCIES AND COMMUNICATION BETWEEN SESSIONS _____ (initial)
I do not provide 24-hour on-call services for problems you may be experiencing. Should you have a mental

health emergency, you options are:

1. You may call my voice mail number and leave a detailed message and phone number.You can expect a return call by the end of the next business day.

2. If your emergency is life-threatening or if you need to reach a mental health professional more quickly than the above option makes possible, I request that you agree to visit your local emergency room or police department. If you cannot get there on your own, you should dial 911 or call 757.362.LIFE (5433).

TEXT MESSAGING

Please note this is *not* an appropriate venue for discussing therapeutic issues, as confidentiality cannot be guaranteed in any communication in written electronic form. However, it may be used for scheduling.

EMAIL

Should you need to communicate via written communication between sessions please use the secure portal. Be advised, however, that any other communication in written electronic form cannot be guaranteed to remain confidential. Therefore, I would discourage you from seeking therapeutic consultation outside of the portal. I cannot respond to every email between sessions, but will work hard to respond in a timely manner.

Since this information is password protected, please identify a username and password that will be easy for you to remember.
(Passwords must be: 8 to 35 characters in length; Contain both letters and numbers; No special characters; letters and numbers only)

FINANCIAL POLICY _____ (initial) FEES

Our sessions will be approximately 50-55 minutes long. Each session will cost out of pocket $120.00. Payment is required in full at each session. A $5.00 billing fee will be applied each month to any account that carries a balance and requires a statement. Additionally, there is also a fee for all returned checks.

There is a charge for services that are not routine in mental health treatment. Such services include, but are not limited to, phone counseling, collaboration with other professionals at your request, and working with your child's school.

INSURANCE

If I am contracted with your insurance company, I will file your claim at no cost to you. Insurance is a contract between you and your insurance company. It is your responsibility to know your benefits before you receive services. If your insurance company requires a referral or preauthorization you are required for obtaining that. **You are responsible for any services your insurance company does not cover (see below).**

CANCELLATIONS/MISSED APPOINTMENT AND OTHER FEES

I recommend that patients set up weekly recurring appointments. Should you need to reschedule or cancel an appointment please let me know as soon as possible. Missed or cancelled appointments delay our work together and interrupt the therapeutic process. Additionally, your spot is reserved for you and prevents someone else from scheduling. If cancellations/rescheduling is frequent I will assume that the current time spot is not working for you and you will need to begin scheduling weekly based on availability. If you would like to receive courtesy reminders of your appointments please check your preference below. **Please understand that these reminders are a courtesy only** and it is still your responsibility to know your appointment time and to provide notice of cancellation within a 24hour period.

Fees not covered by insurance that are your responsibility:

A) Fee for missed sessions without 24 hour cancellation or no show: Insurance contracted rate per session or agreed upon self-pay rate per session if not using insurance

B) Fee for missed session due to 15-minute tardiness: Insurance contracted rate per session or agreed upon self-pay rate per session if not using insurance

C) Fee for Paperwork Completion: $50.00 per 30 minutes

D) Fee for Legal Deposition, Request by Client to participate in legal proceeding, Subpoena for legal disputes involving the client: $300.00 an hour

PAST DUE ACCOUNT

If your account becomes past due we will take the necessary steps to secure payment. You understand that if I refer your account to a collection agency that you will be responsible for all fees (including collection, lawyer and court costs) associated with this process. You understand that if your account is submitted to an attorney or collection agency your status as a client and that you received treatment from me may become a matter of public record. This will result in a *waiver of confidentiality.*

I have read the above information and agree to abide by all conditions. I have had the opportunity to ask questions. Please initial all sections and sign below.

_____ **(sign and date)**

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Authorization for Teletherapy:

Client Name: _____ **Date of Birth:** _____

Address: _____

Phone:_____ **Email:** _____

Technology "How To": Most clients "opt-in" to receive invitations to sessions via email or text. If this is the case for you, you'll receive an email notification, either directly from me or from my HIPAA compliant video software, SecureVideo, to begin online sessions. I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working this way. Please note: None of our sessions will be recorded.

Additional Tips and Awareness About Teletherapy:

- For the first appointment, I will ask you to hold up identification to the camera so I confirm that it is you. This is a legal and ethical consideration as part of providing means through online therapy.
- Always share with me your location. If it is different from your usual spot, I will need to know, in case of an emergency.
- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to the session. I cannot legally guarantee confidentiality on your end of the teletherapy session.
- Turn off notifications on your computer and phone once we are connected.

Emergency and Crisis Support: As a reminder, I am generally in a therapy session during working hours and am unavailable outside for working hours. In an emergency, a client is advised to contact the police, call 911, or go to the nearest hospital emergency room. Clients may also call the National Suicide Hotline at 1-800-273-8255.

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication: Communication with me via any online or electronic means is limited in security and thus your confidentiality may not be guaranteed. I use secure and encrypted (HIPAA compliant) video software for our sessions, SecureVideo. I use secure email and phone systems. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. Security laws (HIPAA laws) state that clients have the freedom to request or "opt-in" to less secure means of communication if they are aware of the risks, comfortable with them, and find it clinically helpful to do so.

Please consider the limits of confidentiality in electronic communications. Please ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy.

1. I attest that I will utilize the means of online or teletherapy in order to access therapy with my therapist.
2. I understand that my therapist is an independent practitioner; therefore, the vendors/ providers she contacts with (video software, messaging software, billing software, documentation software, etc.), are not responsible for or involved in my care or treatment.
3. I attest that the video conferencing, phone conferencing, or digital conferencing technology will be used and that it is not the same as a direct client/mental health care provider visit, due to the fact that I will not be in the same room as my therapist.
4. I understand that a teletherapy treatment has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist may discontinue the teletherapy session if it is felt that the tele means of connection are not adequate for the situation.
6. I understand that teletherapy treatment with my therapist is not an Emergency Service. If I experience a life-threatening emergency, I will call 911, go to the hospital, or implement my developed safety plan.
7. I agree to end each teletherapy session by hitting the "leave session" button and fully close my browser to help ensure my confidentiality.
8. I understand that my therapist cannot guarantee confidentiality in teletherapy due to limits in security on the client's side of the session and I will do my best to ensure I am using secure measures including: turning off other services, applications, programs, and websites from running on my devices during the session and being in a private location.

Client acknowledgement and agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. In addition, I have chosen to opt in to Telehealth. I further waive any and all claims that may arise against Sojourn Counseling & Consulting, PLLC resulting from the use or misuse of text SecureVideo teletherapy.

Client Signature:_____ Date_____

Parent/ Guardian Signature:_____ Date_____

Witness_____ Date_____