Alex L. Andrade Jr., PsyD

Licensed Clinical Psychologist
California PSY28925
Illinois 071.009030
225 30th Street, Suite 306
Sacramento, CA 95816
Telephone: 916-591-6630 E-mail: aandradepsyd@gmail.com

Please complete the following forms. The first page asks for basic information, acknowledgement of HIPPA, payment information, and consent for treatment. The second page includes treatment guidelines. The third page relates to payment information and agreement, including payment options and what steps you will need to take to ensure payment. The fourth page is an informed consent for telepsychological services (in case we need to meet using that format). Finally, the Patient Information Form, starting on the fifth page, will help me better understand your treatment needs and will help guide recommendations. Thank you for taking the time to complete these important forms prior to your first appointment.

Full Legal Name: _____ Date of Birth: _____ Age:_____

Race/Ethnicity: _____ Sex: _____ Preferred Pronoun: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work (A number ok to leave message)

Marital Status: ☐ Married/Relationship ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Presently Living: ☐ Alone ☐ With others (please specify): _____

Home Address: _____

Referred by: _____

HIPAA: I was offered a copy of the HIPAA Form concerning privacy protection by Dr. Andrade.

_____ _____
Signature Date

Payment Information: The full amount of fee-for-service payment is required at the time services are rendered. Initial intake is $240 and follow up sessions are $220.

I hereby authorize treatment for the individual listed above and accept responsibility for the charges incurred for this treatment. I also understand that if I do not give 24 hours notice when canceling an appointment, I will be charged a $100 cancellation fee. In the unlikely failure to remit payment and the credit/debit card is denied, the account will be sent to collections and/or legal action will be pursued. Individuals will be held responsible for all associated fees, including, but not limited to, the cost of collection services, attorneys, administrative support, and the psychologist's time.

_____ _____
Signature Date

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Treatment Guidelines

Emergency Contact: Dr. Alex L. Andrade Jr., PsyD is not available on an emergency or "on-call" basis. Individuals may leave a message, but there may be an extended period of time before Dr. Andrade receives it and/or responds. Individuals requiring immediate assistance must call 911 or go to the nearest emergency room. If patients require additional support, Dr. Andrade will provide a referral that can provide emergency services.

Limits of Treatment: There are rare circumstances in which Dr. Andrade may be obligated to make a unilateral decision to terminate therapy. Such circumstances include, but are not limited to: the current treatment appears to be ineffective; threats are made against Dr. Andrade or his family; Dr. Andrade does not believe he has the necessary training to address a specific problem; or there is a significant therapeutic impasse. In such cases, Dr. Andrade will attempt to find a suitable referral. Dr. Andrade cannot be responsible as to whether this referral is accepted.

Email Communication: Email communication should be limited to issues related to scheduling and billing only. If you have clinical concerns or questions, they are best addressed during your session, or in some cases, over the phone. Email is not an appropriate way of communicating urgent or emergency information. Dr. Andrade will use reasonable means to protect the security and confidentiality of email information sent and received. However, because email is not a totally secure medium, Dr. Andrade cannot guarantee the security of email communication, and is not liable for improper or unintentional disclosure of confidential information.

_____ _____

Signature Date

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Patient Legal Name: _____

Payment Information and Agreement

Initial session is $240 and follow up sessions are $220. The full amount of fee-for-service payment or copay (if using insurance) is required at the time services are rendered. Payment is accepted via cash or debit/credit card. If paying with debit/credit card, payment will be processed via Ivy Pay.

Ivy Pay: This is a HIPAA compliant payment service. Using your mobile phone, you will receive a text message to set up payment using the Ivy Pay secure network. After the initial entering of information, payment will be processed at the end of each session. If there is any change to your debit/credit card information, please update using the Ivy Pay secure network as soon as possible.

By signing below, I agree to be charged for the services as described above. I understand that the fee-for-service or copay amount is due at the time services are rendered. Also, I agree to the $100 cancellation fee (which only applies if I do not give 24 hours notice when canceling a scheduled appointment) being processed via Ivy Pay.

_____ _____
Signature Date

Receipts for each session are available upon your request (and typically include all the necessary information for reimbursement if submitting a superbill to your insurance).

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting telepsychological services, you acknowledge and agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychological services are no longer appropriate and that we should have sessions in-person.

Psychologist Name/Signature: _____ _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

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Patient Information Form

Briefly state the main concerns you would like to discuss:

_____
_____
_____

How long have you had these issues/concerns:

_____
_____
_____

What things have you tried to deal with these issues/concerns:

_____
_____
_____

Have you had any prior therapy experience? (Please describe length of treatment and frequency of visits)

_____
_____
_____

Please check any of the following stresses that apply to you and describe:

☐Major Relocations: _____
☐Job change: _____
☐Deaths: _____
☐Illnesses: _____
☐Marital/Relational Problems: _____
☐Familial Problems: _____
☐Someone significant moving out of the area: _____
☐Experiencing or witnessing a traumatic event: _____
☐Physical or sexual abuse or neglect: _____
☐Legal issues: _____

Occupational History:

Are you currently employed? ☐ Yes ☐ No If so, how long have you worked in this position? _____
Job/Type of Work: _____

Medical History:

Medical Conditions/Concerns:

_____
_____
_____

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Are you taking any medications on an ongoing basis? ☐ Yes ☐ No

Name of Medication	Dosage	Date Started	Name of Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____

Medical/Psychiatric Hospitalization: (Please describe and include dates)

_____

_____

Family history of emotional, behavioral, psychological concerns:

_____

_____

Family history of medical problems:

_____

_____

Please indicate if you have had any history of the following medical problems:

	Check One	Ages	Describe
Asthma	☐ Yes ☐ No		
Chronic Ear Infections	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No		
Hearing/Ear Problems	☐ Yes ☐ No		
Loss of Consciousness	☐ Yes ☐ No		
Nightmares	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No		
Sleep Apnea/Snoring	☐ Yes ☐ No		
Surgeries	☐ Yes ☐ No		
Tics/Twitching	☐ Yes ☐ No		
Vision/Eye Problems	☐ Yes ☐ No		
Alcohol Use/Abuse	☐ Yes ☐ No		
Illicit Drug Use/Abuse	☐ Yes ☐ No		
Risky Behaviors	☐ Yes ☐ No		

Additional Information:
Please list some of your personal strengths:

_____

_____