SECTION OF CONTENTS

Emergency Procedure

IN CASE OF A MENTAL HEALTH EMERGENCY, PLEASE REFER TO THIS LIST OF SERVICES:

- Emergency Services Dial 911
- Crisis Hotline Dial 211
- Suicide Hotline 800-273-8253 (TALK)
- St. Anthony's Hospital 1200 7th Ave. N, St. Petersburg, FL (727) 461-8899

If you are in imminent danger of hurting yourself or someone else and you are experiencing a mental health emergency, contacting the listed services will provide you with immediate attention.

St. Anthony's hospital has a psychiatric behavioral health department that is able to provide assessment and treatment. The other numbers will provide you with an immediate connection to emergency services.

Remember that these services are available to you and you can access them faster than I can respond in an emergency. They will provide you with compassionate and caring service in times of mental health emergencies.

You may reach me after hours at (727) 385-0209 but remember, in an emergency, I cannot respond as quickly as the provided listed services.

This is also the number to call to cancel or reschedule appointments 24 hours prior to your appointment except if your appointment is scheduled on a Monday. In this case, you must call the office on the Friday before your appointment by noon.

CLIENT INTAKE FORM

Please answer the following questions to the best of your ability. These questions are intended to help the therapist with the therapy process. All information is completely confidential.

Personal Information

Name: _____
(First) (Middle) Last)

Date of Birth: _____/_____/_____ Age: _____

Gender: Male ___ Female ___ Transgender ___ Other _____

Martial Status: Never Married ___ Partnered ___ Married ___

Separated ___ Divorced ___ Widowed ___

Number of Children: ___ Ages: _____

Current Address: _____

_____

May we send mail to your home address from this office? Yes ___ No ___

Home Phone: _____ May we leave a message? Yes ___ No ___

Cell Phone: _____ May we leave a message? Yes ___ No ___

Email : _____ May we send you an email? Yes ___ No ___

NOTE: Email may not be confidential

Emergency Contact: Person (Name) _____

Relationship: _____ Phone: _____

Referred by: _____

Are you currently seeing anyone for psychological services, professional counseling, psychiatric services, or any other mental health services Yes ___ No ___

Reason for Change: _____

Have you had any mental health services in the past? Yes ___ No ___
Reason for Change: _____

Are you currently taking any psychiatric medications? Yes ___ No ___
If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? Yes ___ No ___
If yes, please list:

_____

_____

SECTION 3

General Health & Mental Health Information

How is your physical health at the present time?
Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___

List any persistent physical symptoms or health concerns: (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.

_____

_____

Are you taking any medications for physical/medical issues? Yes ___ No ___
If yes, please list:

_____

_____

Are you having any problems with your sleep habits? Yes ___ No___

If yes, check all that applies: Sleep too much ___ Sleep too little ___

Poor quality ___ Disturbing Dreams ___ Other _____

How many times per week do you exercise? _____ Days _____ Minutes/Hour

Are there any changes or difficulties with your eating habit? Yes ___ No___
If yes: Eating less ___ Eating more ___ Binging ___ Restricting ___

Have you experienced a weight change in the last two months? Yes ___ No___

Do you consume alcohol regular? Yes ___ No___
In a month, how many times do you have 4 or more drinks in a 24-hours? _____

How often do you engage in recreational drug use?
Daily ___ Weekly ___ Monthly ___ Rarely ___ Never ___

Do you currently or have you ever used tobacco in any form; e.g.: cigarettes, cigars, chew, vape, etc.? Yes ___ No ___

Have you felt depressed recently? Yes ___ No ___ If yes, for how long? _____

Have you had any suicidal thoughts recently? Yes ___ No ___
If yes: Frequently ___ Sometimes ___ Rarely ___

Have you had suicidal thoughts in your past? Yes ___ No ___
If yes, how long ago? _____ How often? Frequently ___ Sometimes ___ Rarely ___

Are you currently in a romantic relationship? Yes ___ No ___
If yes, how long have you been in this relationship? _____

Do you feel safe in your home? Yes ___ No ___

Do you have a history of or are you currently experiencing any form of domestic abuse? Yes ___ No ___

On a scale from 1 to 10, how would you rate the quality of your relationship (10 being great)? _____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, etc.) Yes ___ No ___

_____

_____

Quick Check

Please check all of the symptoms you have experienced:

___ Extreme depressed mood
___ Mood swings
___ Rapid speech
___ Extreme anxiety
___ Panic attacks
___ Phobias
___ Disturbed sleep
___ Hallucinations
___ Memory lapse
___ Alcohol / Substance abuse
___ Body complaints
___ Eating disorder
___ Repetitive thoughts
___ Anxiety
___ Time loss
___ Repetitive behaviors
___ Homicidal thoughts
___ Suicide attempts
___ Trouble planning
___ Relationship trouble

SECTION 5

Occupational Information

Are you currently employed? Yes ___ No___
If yes, who's your employer? _____

What is your position? _____

Are you happy in your current position? Yes ___ No___

Are you fulfilled in your current position? Yes ___ No___

Does your work make you stressed? Yes ___ No___

If yes, what are your work-related stressors? _____

_____

_____

_____

Religious /Spiritual Information

Do you practice a religion? Yes ___ No___

If so, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes ___ No___

What gives meaning to your life? _____

_____

SECTION 7

Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

Issue		Family Member
Depression	Yes ___ No___	_____
Anxiety Disorder	Yes ___ No___	_____
Bipolar Disorder	Yes ___ No___	_____
Panic Attacks	Yes ___ No___	_____
Alcohol / Substance Abuse	Yes ___ No___	_____
Eating Disorder	Yes ___ No___	_____
Learning Disability	Yes ___ No___	_____
Trauma History	Yes ___ No___	_____
Domestic Violence	Yes ___ No___	_____
Obesity	Yes ___ No___	_____
Obsessive Compulsive Behavior	Yes ___ No___	_____
Schizophrenia	Yes ___ No___	_____

Other Information

List your strengths _____

_____

List areas you feel you need to develop _____

_____

_____

What do you like most about yourself _____

_____

What are some ways you cope with obstacles and stress? _____

_____

_____

What brought you to therapy today? What would you like to accomplish?

_____

_____

_____

Informed Consent

I authorize Renee C. Gillombardo, LMFT, PA to provide me with psychological services. I make this request freely and without coercion, I understand the risks and benefits of treatment and that experiencing thoughts or feelings that have been unexpressed may produce an emotional response that may be uncomfortable and may impact my relationships. I understand that I have the right to terminate treatment at anytime. It is our preference that you discuss your desire to terminate in advance so there en be proper closure and appropriate referral provided when necessary. The therapist may be ethically bound to terminate therapy if it is reasonably clear that the patient is not benefiting from therapy. I further understand that Renee C. Gillombardo, LMFT, PA and representatives cannot guarantee confidentiality of your **Protected Health Information** in the event you choose to use electronic transmission of any type, including but not limited to e-mail, text, social media Skype site to transmit **Protected Health Information**. _____ (initial)

Additionally, audio or video tapping of the sessions is not allowed. Audio or video tapping of a session will result in termination of the therapeutic relationship. _____ (initial)

I agree to turn off cell phone during session _____ (initial)

I understand that this office will not return calls to confirm appointments. _____ (initial)

Informed Consent continued

I understand my right of confidentiality is protected by Federal and State regulations. I further understand that my therapist is required or allowed by law to breach confidentiality in the following situations

- A danger to self or an identified person or their property
- Unable to care for self and your life is in danger
- Suspicion of abuse/neglect/endangerment of a child or observation or information of abuse of an elder
- Receipt by this office of a court order requesting release of your records, your arrest or an order to testify in a court proceeding.

Counseling and psychotherapy is a joint effort between patient and therapist. The patient is often required to express and experience painful and challenging beliefs and behaviors that are the essence of the difficulties in their life. We believe that the patient is the "change agent" and a strong commitment is necessary for lasting changes. We will provide the safe environment, clinical skill and expertise to help you navigate through the changes you wish to make. If you have any questions concerning this informed consent, lease ask your provider.

Patient Signature _____

Print Name _____ Date: _____

Informed Consent continued

Financial Policy Agreement

My insurance policy is a contract between my insurance company and me. I understand Renee C. Gillombardo, LMFT, PA will submit bills to my insurance company. I am responsible for any co-payments, deductibles, or amounts, which my insurance company does not pay to Renee C. Gillombardo, LMFT, PA _____ (initial)

Payment for services are due the day service is rendered. AII insurance co-payments are due the day services are rendered. This office does not bill for services rendered. _____ (initial)

We accept checks and cash payments. This office is a primary provider for Cigna Behavioral Health Care, United Health Care, and Blue Cross Blue Shield. If you wish to use another PPO insurance plan, we will provide the information you will need to submit to your insurance provider to receive partial reimbursement for services based on your specific insurance coverage. _____ (initial)

Since a 24-hour notice is required for cancellation, no show or reschedule of an appointment, you will be charged the full fee for services not cancelled within 24-hours, or if you do not show for an appointment if your appointment is on a Monday and you wish to cancel or reschedule your appointment, you must notify the office via voicemail the Friday before your appointment before 3:00 pm. _____ (initial)

Informed Consent continued

Checks returned for insufficient funds are subject to prosecution under the laws of the State of Florida. You will be charged a $35.00 service charge on any returned checks. Please note that this office does not refer delinquent accounts to a collection agency when satisfactory arrangements cannot be made. _____ (initial)

Important Notice: You have been advised that my office has an off-site insurance billing associate. This person is HIPAA compliant and does meet HIPPA regulations to protect your PHI. An encrypted email service is used to transmit billing information from my office to the associate. Only information necessary to bill your insurance is provided to the associate and he has no access to your clinical files. The encrypted service is Hushmail and they are a HIPPA compliant company. Please initial your achowledgement. _____ (initial)

We hope this policy statement will be helpful to you in understanding your financial obligations to this office. Your signature below acknowledges your acceptance of this financial agreement.

Patient Signature _____

Cigna, United Health Care, and Blue Cross Blue Shield patients only:

Insurance Subscriber's Name _____

Insured Date of Birth: _____ SS# _____

Informed Consent continued

Notice of Policies and Practices to Protect the Privacy of Patient's Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. Uses and disclosures for treatment, payment and health care operations.

Renee Gillombardo, LMFT may use or disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations with your consent. The following definitions clarify these terms.

- PHI refers to information in your patient record that could identify you.
- Treatment, payment and health care operations.
  - Treatment is when Renee Gillombardo, LMFT provides, coordinates or manages your health care and other services related to your health care.
  - Payment is when Renee Gillombardo, LMFT obtains reimbursement for your health care. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health care operations are activities that relate to the performance and operations of this business. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services and care coordination.
  - Use applies only to activities outside of this business such as releasing, transferring or providing access to information that identifies you.
  - Disclosure applies to activities outside of this business such as releasing, transferring or providing access to information about you to other parties.

Informed Consent continued

2. Uses and disclosures requiring authorization

Renee Gillombardo, LMFT may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when information is sought for purposes outside of treatment, payment, or health care operations, an authorization will be obtained from you before releasing information. An authorization is also necessary before releasing your psychotherapy notes. Psychotherapy notes are notes made about conversations during a private group, joint or family counseling session, which are kept separate from the rest of your patient record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Renee Gillombardo, LMFT has relied on that authorization or (2) the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the righ to contest the claim under the policy.

Informed Consent continued

3. Uses and disclosures with neither consent nor authorization

Renee Gillombardo, LMFT, PA may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If knows or has reasonable cause to suspect that child is abused, abandoned or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that Renee Gillombardo, LMFT report such knowledge or suspicion to the Florida Department of Children and Families.
- **Adult and Domestic Abuse**: If Renee Gillombardo, LMFT knows or has reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abuse, neglected or exploited, Renee Gillombardo, LMFT is required by law to immediately report such knowledge or suspicion to the Florida Abuse Hotline.
- **Health Oversight**: If a complaint is filed against Renee Gillombardo, LMFT with the Florida Department of Health or other regulation board, the Department has the authority to subpoena confidential mental health information from Renee Gillombardo, LMFT relevant to that compliant.

Informed Consent continued

- **Judicial or Administrative proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and Renee Gillombardo, LMFT will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform Renee Gillombardo, LMFT that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious threat to health or safety**: When you present a clear and immediate probability of physical harm to yourself, or other individuals or to society, Renee Gillombardo, LMFT may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement or other appropriate authorities.
- Workers Compensation: If you file a worker's compensation claim, Renee Gillombardo, LMFT must, upon request of your employer, the insurance carrier, and authorized qualified rehabilitation provider or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

Informed Consent continued

4. Patient's rights and Renee Gillombardo, LMFT responsibilities

Patient's rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of PHI about you. However, Renee Gillombardo, LMFT is not required to agree to a restriction you request.
- Right to Receive Confidential Communication by Alternative Means of Alternative Locations - You have the right to request and received confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are receiving services. Upon request, bills will be sent to another address.
- Right to Inspect and Copy - You have the right to inspect or obtain a copy or both of PHI in Renee Gillombardo, LMFT mental health or billing records used to make decisions about you for as long as the PHI is maintained in the record. At your request Renee Gillombardo, LMFT will discuss wit you the details of the request process.
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied. At your request, Renee Gillombardo, LMFT will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, Renee Gillombardo, LMFT will discuss with you the details of the amendment process.
- Right to Paper Copy - You have the right to obtain a paper copy of the notice from Renee Gillombardo, LMFT upon request, even if you have agreed to receive the notice electronically.

Informed Consent continued

Renee Gillombardo, LMFT Responsibilities:

- Renee Gillombardo, LMFT is required by law to maintain the privacy of PHI and to provide you with a notice of its legal duties and privacy practices with respect to PHI.
- Renee Gillombardo, LMFT reserves the right to change the privacy policy and practices described in this notice. Unless Renee Gillombardo, LMFT revises its policies and procedures, it will provide you with a revised notice by mail as well as making that information available in all its offices.

5. Complaints

If you are concerned that your privacy rights have been violated or if you disagree with a decision that has been made about access to your records, please feel free to discuss your concerns with your therapist.

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. I can provide you with the appropriate address upon request.

6. Effective Date and Changes to Privacy Policy

This notice will go into effect on April 14, 2003

Renee Gillombardo, LMFT reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. Renee Gillombardo, LMFT will provide you with a revised notice by mail as well as making that information available.

Informed Consent continued

7. Acknowledgement of Receipt of HIPPA Privacy Notice

Renee Gillombardo, LMFT has explained A. the ways that my identifying information is protected B. the times when information about me may be released with specific permission and C. my rights related to my medical information.

Patient Signature _____

Date _____

Witness Signature _____

Date _____

THIS ACKNOWLEDGEMENT WILL BE RETAINED IN YOUR CLINICAL RECORD

Online Informed Consent for Teletherapy Mental Health Treatment Services

In Response to COVID-19

Teletherapy mental health services occur through interactive videoconferencing with audio communication, and includes the practice of goal setting, accountability, referral to resources, problem solving, skills training, and help with decision-making. Teletherapy mental health services may also include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment.

Please carefully read through the following statements to be sure that you understand the expectations, possible benefits, risks, and crisis procedures associated with participation in teletherapy mental health services with Renee Gillombardo, LMFT. You will be asked to provide your consent to engage in teletherapy mental health services by providing your electronic signature at the end of this form.

To participate in teletherapy mental health services with Renee Gillombardo, LMFT, I understand the following:

1. I will need a desktop or laptop computer, or tablet device with a camera for videoconferencing, speakers or headphones, and a good, private and secure internet connection. I will need to be in a private location to ensure my privacy.

2. I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, I may request a referral to a local mental health provider.

3. I understand that Renee Gillombardo, LMFT will inform me if teletherapy mental health services are appropriate for me. Receiving teletherapy mental health services may not be appropriate when:

- There has been a recent suicide attempt, psychiatric hospitalization, or psychotic process (e.g., in the last three years);
- Moderate to severe major depression or bipolar disorder syndrome;

Online Informed Consent for Teletherapy Mental Health Treatment Services continued

- Moderate to severe alcohol or drug abuse;
- Severe eating disorder;
- Repeated acute crises (e.g., occurring once a month or more frequently)
- Renee Gillombardo, LMFT determines, based on clinical judgement, that teletherapy mental health services are not an appropriate mode of treatment.

4. There are risks and consequences from receiving teletherapy mental health services, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

5. Teletherapy mental health-based services and care may not be as complete as onsite, in-person services. I also understand that if my therapist believes I would be better served by another form of intervention (including onsite, in-person services), I may be referred to a mental health professional who can provide these services in my area.

6. My therapist will initiate each scheduled video-conference through the Doxy.me platform. My therapist will make three attempts to contact me within 10 minutes of the start of our session. If I do not answer the video-conference in three attempts, I understand that I may be charged for that session and the session will need to be re-scheduled.

7. Certain situations, including emergencies and crises, are inappropriate for video/computer based psychological therapy services. My therapist will appropriately monitor and respond to any struggles I may be having, If my counselor is concerned about me, loses contact with me, or if I fail to show for a scheduled tele-mental health session, I understand that my counselor will attempt to contact me to check on my well-being.

Online Informed Consent for Teletherapy Mental Health Treatment Services continued

8. To receive teletherapy mental health services, I must be physically located in Florida where Renee Gillombardo, LMFT is licensed to provide mental health treatment services. Teletherapy mental health services may not be provided if you are out-of-state or in an international locale at the time of your scheduled appointment. Renee Gillombardo, LMFT will establish your location at the beginning of every session, and you are strongly recommended to remain in the same location for each session.

9. The laws that protect the confidentiality of your personal information also apply to teletherapy mental health. As such, the information disclosed during the course of sessions is not disclosed to anyone without your written permission. However, Florida law establishes that confidentiality does not apply under the following circumstances:

- You are considered an immediate risk for harming yourself;
- You are considered an immediate risk of harming others;
- Child abuse;
- Abuse of elderly person or persons with disabilities;
- A court order.

10. No personally identifiable images or information from the teletherapy mental health interaction will be made and/or disseminated to anyone without your written consent. Clients are prohibited from recording their teletherapy mental health sessions.

If I show indicators that I may be in real trouble, including a serious risk for self-harm or harm to others, I grant Renee Gillombardo, LMFT permission to contact someone to insure my safety. The information given on my initial intake form will be used for office procedure guidelines in these crisis situations.

My signature on the initial intake consent form with Renee C. Gillombardo, LMFT, PA. reflects that I have been informed about the policies and procedures for teletherapy mental health services, and I agree to them.

Informed Consent For In-person Services During COVID-19 Public Health Crisis

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. By reading this document, and signing your initial intake form which references this consent, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via teletherapy. If you have concerns about meeting through teletherapy, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to teletherapy for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, teletherapy services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for teletherapy services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Informed Consent For In-person Services During COVID-19 Public Health Crisis continued

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a teletherapy arrangement.

You will only keep your in-person appointment if you are symptom free.

You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using teletherapy. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.

You will wait in your car or outside until no earlier than 5 minutes before our appointment time.

You will wash your hands or use alcohol-based hand sanitizer prior to entering the building.

You will adhere to the safe distancing precautions we have set up in the waiting room. For example, you won't move chairs or sit where we have signs asking you not to sit. Currently our waiting room is closed in an abundance of caution.

You will wear a mask in all areas of the office. I may wear a face shield or mask as well.

You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me.

You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

Informed Consent For In-person Services During COVID-19 Public Health Crisis continued

If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.

You will take steps between appointments to minimize your exposure to COVID. If you have a job that exposes you to other people who are infected, you will immediately let me know.

If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.

If a resident of your home tests positive for the infection, you will immediately let me know and we will then begin or resume treatment via teletherapy.

I may change the above precautions if additional local, Florida State or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the Coronavirus within the office and to maintain a safe and healthy environment. We have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts. We are not liable if you contract Coronavirus, and you agree to hold harmless Renee C. Gillombardo, LMFT, PA.

Informed Consent For In-person Services During COVID-19 Public Health Crisis continued

If You or I Are Sick

You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by teletherapy as appropriate. I may ask that I take your temperature with a thermoscan thermometer.

If I test positive for the coronavirus, you will be notified so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the Coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By reading and signing your initial intake consent form, you are agreeing that I may do so without an additional signed release.

My signature on the initial intake consent form with Renee C. Gillombardo, LMFT, PA. reflects that I have been informed about the policies and procedures for In-Person Services during the COVID-19 Public Health Crisis, and I agree to them.