

Adult ESA Evaluation Client Packet

Virtual Therapy FL | Aileen Abello Rivera LMHC

This packet contains the documents required before an adult emotional support animal clinical evaluation. Complete all applicable sections through the secure client portal. Completion does not guarantee that documentation will be issued.

Packet Contents

- Telehealth Informed Consent
- Notice of Privacy Practices and Acknowledgment
- ESA Evaluation Agreement and Financial Policies
- Secure Upload and Scheduling Instructions
- Adult ESA Evaluation Questionnaire
- Optional Authorization to Release or Obtain Information

Before Your Appointment

1. Complete and sign the consent, acknowledgment, evaluation agreement, and questionnaire. 2. Securely upload any applicable housing forms, correspondence, prior ESA documentation, treatment summaries, diagnostic evaluations, or accommodation records. 3. Schedule a 45 to 60 minute live telehealth evaluation. 4. Be physically located in Florida during the appointment and have a government-issued photo ID available.

Scheduling link:

<https://bookings.cloud.microsoft/book/VirtualTherapyFL@NETORG19330325.onmicrosoft.com/?ismsaljsauthenabed>

Please return completed clinical forms through my HIPAA-compliant email. Standardized measures may be assigned separately when clinically indicated.

Client full legal name

Date of birth

Date completed

Telehealth Informed Consent

Telehealth uses electronic communications to provide clinical services when the client and clinician are in different locations. The ESA evaluation may include live video or, when clinically appropriate, audio communication; review of questionnaires and records; assessment; education; and clinical documentation.

Nature and Limits of Telehealth

- ☐ I understand that telehealth has potential benefits, including convenience and access, and potential risks, including technology failure, interruptions, unauthorized access, privacy limitations in my location, or reduced access to information normally available in person.
- ☐ I understand that I must participate from a reasonably private location, use a secure device and connection when possible, and tell the clinician if another person is present.
- ☐ I understand that I must be physically located in Florida at the time of the appointment. I will provide my exact physical location and an emergency contact at the beginning of the session.
- ☐ I understand that the clinician may determine that telehealth is not clinically sufficient and may recommend another appointment, collateral information, in-person care, crisis services, or referral.
- ☐ I understand that telehealth is not an emergency service. If I am in immediate danger, I will call 911 or 988 or go to the nearest emergency department.
- ☐ I understand that the appointment may be interrupted by technology problems. If disconnected, I will attempt to reconnect and monitor the phone number or secure portal associated with my appointment.
- ☐ I understand that sessions will not be recorded by either party without prior written agreement.

Consent

- ☐ I have had the opportunity to ask questions, understand the benefits and risks described above, and voluntarily consent to receive this evaluation through telehealth.

Client typed signature

Printed name

Date

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you may access that information. Please review it carefully. Virtual Therapy FL is committed to protecting the privacy and security of your protected health information.

Uses and Disclosures

Your health information may be used or disclosed for treatment, payment, and healthcare operations as permitted by law. Examples include conducting and documenting your evaluation, coordinating care with authorization when required, processing payment, maintaining records, quality review, and lawful business operations. Information may also be disclosed when required or permitted by law, including certain emergencies; suspected abuse, neglect, or exploitation; serious and imminent threats; health oversight; judicial or administrative proceedings; law enforcement requests; workers compensation; public health activities; and other legally authorized purposes.

Uses or disclosures not otherwise permitted will generally require your written authorization. You may revoke an authorization in writing except to the extent action has already been taken in reliance on it. Virtual Therapy FL will disclose only the information reasonably necessary for the permitted purpose when the minimum-necessary standard applies.

Your Rights

- Request access to or copies of your designated clinical record, subject to lawful limitations.
- Request an amendment if you believe information is inaccurate or incomplete.
- Request restrictions on certain uses or disclosures. Not every request can be accepted.
- Request confidential communications by a reasonable alternative method or at an alternative location.
- Request an accounting of certain disclosures.
- Receive a paper or electronic copy of this notice.
- File a complaint without retaliation if you believe your privacy rights were violated.

Contact and Complaints

Questions, privacy requests, or complaints may be directed to Aileen Abello Rivera, LMHC, Virtual Therapy FL, at aileen@virtualtherapyfl.com or (305) 330-2936. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at <https://www.hhs.gov/ocr/privacy/hipaa/complaints/>. You will not be retaliated against for filing a complaint.

Virtual Therapy FL reserves the right to revise this notice as permitted by law. The current notice will apply to health information maintained by the practice and will be made available upon request and through the practice website or portal when applicable.

Acknowledgment of Receipt

☐ I acknowledge that I received and reviewed the Virtual Therapy FL Notice of Privacy Practices.

Client typed signature

Printed name

Date

ESA Evaluation Agreement and Financial Policies

This service is an independent clinical evaluation of whether emotional support animal documentation is clinically appropriate for a housing-accommodation request. It is not the sale of a letter, registration, certificate, or predetermined opinion.

Client Understandings

- ☐ I understand that payment covers professional time, assessment, record review, clinical judgment, and related documentation, not a guaranteed letter or housing-provider approval.
- ☐ I understand that a recommendation will be issued only when supported by the completed evaluation and the clinician has sufficient personal knowledge of my disability and disability-related need for the specific animal.
- ☐ I understand that additional records, collateral information, assessment measures, or another appointment may be required before a decision can be made.
- ☐ I understand that a diagnosis alone does not automatically establish eligibility and that the evaluation must address functional limitation and the specific animal-related need.
- ☐ I understand that an ESA is not automatically a service animal and this service does not create airline, restaurant, workplace, school, or general public-access rights.
- ☐ I understand that the clinician does not certify the animal's training, health, behavior, temperament, vaccination status, or safety.
- ☐ I understand that the housing provider makes the accommodation decision, and the clinician cannot guarantee acceptance.
- ☐ I agree to provide complete and accurate information and not request backdating, false statements, or documentation of services that did not occur.
- ☐ I agree not to alter, deceptively reproduce, transfer, or misuse any documentation issued.
- ☐ I understand that separate clinical justification is required for every animal when more than one animal is requested.
- ☐ I understand that communication with a landlord, HOA, property manager, attorney, family member, or other third party requires an appropriate written authorization unless disclosure is otherwise permitted or required by law.

Cancellation Rescheduling and Refunds

Cancel or reschedule at least 24 hours before the appointment for a full refund or free rebooking. Missed appointments and late cancellations may be charged in full because the clinical time was reserved. Once the evaluation has begun, the evaluation fee is nonrefundable, including when the determination is that ESA documentation is not clinically appropriate. Updated evaluations are not automatic and are charged at the current evaluation rate. Lengthy additional forms, repeated third-party requests, or work outside the initial service may involve a fee disclosed in advance.

- ☐ I have reviewed and agree to the ESA evaluation, cancellation, rescheduling, no-show, refund, additional-service, and updated-evaluation policies.

Client typed signature

Printed name

Date

Secure Upload and Scheduling Instructions

Please submit documents through my HIPAA-compliant email. This includes clinical questionnaires, diagnoses, medication information, treatment records, and other protected health information.

Upload When Applicable

- ☐ Landlord, HOA, condominium association, or property-management forms and correspondence.
- ☐ Written accommodation request, denial, deadline, lease provision, or animal-related policy.
- ☐ Previous ESA documentation.
- ☐ Relevant treatment summary, diagnostic evaluation, psychological evaluation, or accommodation documentation.
- ☐ Information concerning more than one requested animal.
- ☐ Any document the clinician specifically requests after reviewing the questionnaire.

Scheduling

Schedule a 45 to 60 minute live evaluation at:

<https://bookings.cloud.microsoft/book/VirtualTherapyFL@NETORG19330325.onmicrosoft.com/?ismsaljsauthenabed>

At the appointment, have a government-issued photo ID available. You must be physically located in Florida and prepared to provide your exact location and emergency contact. The clinician may assign standardized measures after reviewing your presenting concern. Measures support but do not replace the clinical evaluation.

Client Preparation Checklist

- ☐ Completed telehealth consent
- ☐ Reviewed privacy notice and signed acknowledgment
- ☐ Completed ESA evaluation agreement
- ☐ Completed adult ESA questionnaire
- ☐ Uploaded applicable housing documents
- ☐ Uploaded relevant prior documentation if available
- ☐ Scheduled live evaluation
- ☐ Prepared photo identification and private Florida location

Adult Emotional Support Animal Evaluation Questionnaire

Virtual Therapy FL | Aileen Abello Rivera LMHC

Purpose. This questionnaire helps the clinician understand your mental health history, daily functioning, housing-related request, and relationship with the specific animal. Completing it does not guarantee an ESA recommendation or letter. Payment is for clinical evaluation time and professional judgment, not for a predetermined outcome.

Privacy. Please complete and return this form through my HIPAA-compliant email. Use this email to submit clinical details, diagnoses, medication information, and completed questionnaires.

Client Information

Full legal name

Preferred name

Date of birth

Phone

Email

Florida home address

Emergency contact

Relationship

Emergency phone

A. Will you be physically located in Florida at the time of the evaluation?

☐ Yes ☐ No ☐ Unsure

B. What language do you prefer for the evaluation?

☐ English ☐ Spanish ☐ Either

Nature of the Request

1. Please describe exactly what you are requesting and why you are requesting it now.

2. Is this request specifically for a housing accommodation?

☐ Yes ☐ No ☐ Unsure

3. Are you requesting airline, travel, workplace, school, restaurant, or public-access privileges?

☐ No ☐ Yes

If yes, explain. ESA documentation does not create airline or public-access rights.

4. Describe your present or anticipated housing situation, including restrictions, fees, deadlines, or communications.

5. Has a housing provider provided its own form or written request?

☐ No ☐ Yes

If yes, securely upload it and describe any deadline.

6. Have you previously received ESA documentation?

☐ No ☐ Yes

If yes, identify provider, approximate date, animal, and reason for reevaluation.

7. Has a request ever been denied, questioned, investigated, or involved in a legal dispute?

☐ No ☐ Yes

If yes, explain and securely upload relevant correspondence.

8. Are you requesting backdating or a statement that treatment occurred when it did not?

☐ No ☐ Yes

Mental Health and Treatment History

9. What emotional, behavioral, or mental health concerns are you currently experiencing?

10. When did these concerns begin, how often do they occur, and how long do they last?

11. What makes the concerns better or worse?

12. List current or prior diagnoses, who made each diagnosis, and approximately when.

13. Describe current or prior therapy, psychiatric care, hospitalization, crisis care, or other treatment.

14. List current medications relevant to mental or emotional health, the prescriber, and whether they help.

15. Describe relevant medical, neurological, developmental, substance-use, sleep, or pain conditions.

16. Identify current treating professionals and whether you would authorize limited contact if needed.

Safety Information

17. During the past month, have you had thoughts of harming yourself or not wanting to be alive?

☐ No ☐ Yes ☐ Prefer to discuss live

18. During the past month, have you had thoughts of harming another person?

☐ No ☐ Yes ☐ Prefer to discuss live

19. Are you currently in immediate danger or experiencing a mental health emergency?

☐ No ☐ Yes

If you are in immediate danger, call 911 or 988 or go to the nearest emergency department. Submitting this form is not an emergency service and may not be reviewed immediately.

Functional Impact

For each area, mark the current level of interference caused by your mental or emotional condition.

F1. Sleeping

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F2. Concentrating or thinking

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F3. Working

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F4. Learning or schoolwork

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F5. Caring for yourself

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F6. Leaving home or traveling locally

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F7. Interacting with others

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F8. Communicating

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F9. Managing emotions

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F10. Maintaining routines or household responsibilities

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

F11. Other major life activity

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Severe

20. Provide at least three recent, concrete examples of what has become difficult, limited, avoided, or substantially harder.

21. How frequently do these limitations occur, and how long have they affected you?

22. What treatments, accommodations, coping strategies, or supports have you tried?
What was the result?

Animal Information

Animal name	Species	Breed if known
Age	Sex	Approximate weight
How long known	Current owner	

Where does the animal currently live?

23. Do you currently live with this animal?

☐ Yes ☐ No ☐ Sometimes

24. Describe how often and in what settings you interact with the animal.

25. Who is responsible for feeding, walking, cleaning, veterinary care, and other daily needs?

26. Is the animal licensed and vaccinated as required by applicable state or local rules?

☐ Yes ☐ No ☐ Unsure ☐ Not applicable

27. Has the animal ever bitten, attacked, seriously injured, threatened, or caused substantial property damage?

☐ No ☐ Yes ☐ Unsure

If yes or unsure, explain the circumstances, outcome, and steps taken.

28. Are there concerns about aggression, uncontrolled behavior, sanitation, neglect, or ability to provide care?

☐ No ☐ Yes ☐ Unsure

If yes or unsure, explain.

Disability Related Need for This Specific Animal

29. Identify the specific symptoms or effects of your condition that this particular animal helps alleviate.

30. Describe exactly what the animal does, or how its presence affects those symptoms or your functioning.

31. Provide at least three recent examples of the animal helping you function in your home or alleviating an identified symptom or effect.

32. What happens to your symptoms or functioning when the animal is not available?

33. How is this support different from ordinary companionship, comfort, enjoyment, or preference for a pet?

34. Why is living with this animal necessary for you to use and enjoy your housing?

35. What other treatments, supports, or coping skills do you use in addition to the animal?

Requests Involving More Than One Animal

36. Are you requesting an accommodation for more than one animal?

☐ No ☐ Yes

If yes, complete this section separately for each additional animal. Each animal must have an individually supportable disability-related purpose.

Additional animal name, species, age, ownership history, and length of relationship.

What distinct symptom, effect, or functional limitation does this animal address?

How does this support differ from the support provided by the other animal or animals?

Why could the identified need not be adequately addressed by one animal?

Additional Information and Records

37. Is there anything else the clinician should understand before the evaluation?

38. Would you authorize the clinician to request limited information from a current or prior provider if clinically necessary?

☐ Yes ☐ No ☐ Discuss first

Possible supporting records include a treatment summary, prior diagnostic evaluation, relevant accommodation documentation, or housing correspondence. Records do not replace the clinician's independent evaluation.

Client Acknowledgment

- ☐ I understand that I am requesting a clinical evaluation, not purchasing a letter or guaranteed outcome.
- ☐ I understand that this questionnaire does not establish eligibility and does not replace a live clinical evaluation.

- ☐ I understand that additional appointments, records, collateral information, or referral may be required.
- ☐ I understand that an ESA is not automatically a service animal and does not receive public-access or airline rights.
- ☐ I understand that the clinician does not certify the animal's training, health, behavior, temperament, vaccination status, or safety.
- ☐ I understand that a housing provider makes the final accommodation decision and acceptance cannot be guaranteed.
- ☐ I agree not to alter, deceptively reproduce, or misuse any document issued.
- ☐ I certify that my responses are complete and accurate to the best of my knowledge.

Typed signature

Printed name

Date

Clinician Use Only

Complete after record review and the live evaluation. This section is not completed by the client.

- ☐ Identity verified
- ☐ Client location in Florida verified
- ☐ Consent and evaluation agreement completed
- ☐ Live evaluation completed
- ☐ Mental status and safety assessed
- ☐ Functional impairment evaluated
- ☐ Specific animal nexus evaluated
- ☐ Multiple animals evaluated separately if applicable
- ☐ Collateral information reviewed or documented as unnecessary
- ☐ Inconsistencies resolved or documented
- ☐ Clinical determination supported by the complete record
- ☐ Client educated regarding housing-only limitations

C1. Clinical outcome

- ☐ Documentation supported ☐ Additional information needed ☐ Not supported at this time
- ☐ Referral indicated

Clinical rationale and next steps

Clinician typed signature

Credentials

Date

Optional Authorization to Release or Obtain Information

Complete this form only when you want Virtual Therapy FL to communicate with another person or organization. A separate authorization may be requested when different recipients or different purposes are involved.

Client full legal name

Date of birth

Person or organization authorized to disclose information

Phone

Fax

Email

Person or organization authorized to receive information

Phone

Fax

Email

Information Authorized

- ☐ ESA evaluation questionnaire and clinical evaluation information
- ☐ Relevant treatment summary
- ☐ Diagnostic or psychological evaluation
- ☐ Housing form or accommodation correspondence
- ☐ Verification of document authenticity
- ☐ Attendance and appointment information
- ☐ Other information described below

Other information or specific limitations

Purpose of disclosure

Expiration and Rights

R1. This authorization expires

- ☐ On the date below ☐ When the stated purpose is completed ☐ One year after signature

Expiration date if selected

I understand that I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits will not generally be conditioned on signing this authorization. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy rules, although other laws may still apply.

☐ I authorize the disclosure or exchange described above and confirm that I have completed all applicable sections.

Client typed signature

Printed name

Date

Personal representative if applicable

Relationship or authority

PHQ-9 - Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Client name:

Date:

Response options: 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked 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?

- ☐ Not difficult at all
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

Clinician total score (0-27):

Clinical note: Any response above 0 on item 9 requires timely follow-up and safety assessment.

Screening tool only; results do not independently establish diagnosis or ESA eligibility.

GAD-7 - Generalized Anxiety Disorder

Over the last 2 weeks, how often have you been bothered by the following problems?

Client name:

Date:

Response options: 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

	0	1	2	3
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

If you checked 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?

- ☐ Not difficult at all
 ☐ Somewhat difficult
 ☐ Very difficult
 ☐ Extremely difficult

Clinician total score (0-21):

Screening tool only; interpret in clinical context and assess functional impairment independently.