
# VdV Soundboard

## Comprehensive Intake and Authorization Form

For support services centered on clear communication, practical guidance, and thoughtful next steps.

**Instructions**

1. Complete Section 1 for all clients.
2. Complete Section 2 only if you are requesting Medical Navigation Support.
3. Complete Section 3 only if support involves a criminal justice matter, juvenile matter, or family support connected to those issues.
4. Sign and date all sections that apply to your request.
5. Return the completed form to VdV Soundboard for review before services begin.

*This form is for intake and authorization purposes only. It does not create an attorney-client, medical-provider, or therapist-client relationship.*

## 1. General Client Intake

*Please complete this section for all clients.*

### A. Basic Information

| | |
|---|---|
| **Full name** | |
| **Preferred name / nickname (if any)** | |
| **Date of birth (MM/DD/YYYY)** | |
| **Phone number** | |
| **Email address** | |
| **Mailing address (optional)** | |

### B. Emergency Contact (Optional)

| | |
|---|---|
| **Emergency contact name** | |
| **Relationship to you** | |
| **Phone number** | |

### C. Preferred Method of Communication

☐ Phone call ☐ Text

☐ Email ☐ Video chat

## D. Which Service(s) Are You Interested In?

- ☐ Medical Navigation Support
- ☐ Divorce and Separation Support
- ☐ Criminal Justice and Juvenile Family Support
- ☐ Everyday Support and Communication Help
- ☐ Message, Letter, or Communication Drafting
- ☐ Judgment-Free Listening / Sounding Board Support

**Preferred support format (check all that apply)**

- ☐ One-time session
- ☐ Ongoing support
- ☐ As-needed check-ins

**E. Briefly describe why you are seeking support**

## F. Legal / Attorney Information (If Applicable)

**Is this matter related to a legal proceeding?**

☐ Yes ☐ No

| | |
|---|---|
| **County / jurisdiction (if known)** | |
| **Case number (if known)** | |
| **Attorney name** | |
| **Is your attorney aware you are seeking these services? ☐ Yes ☐ No** | |
| **Attorney contact information (phone / email)** | |

**G. Additional comments or questions**

## H. Privacy and Non-Professional Relationship Acknowledgment

**By signing below, I acknowledge that Robert van der Vijver is not a licensed therapist, medical professional, or attorney.** Services are provided as practical support and guidance based on experience and do not replace legal, medical, or mental health advice. Information shared will be handled with care and discretion. If medical information is shared for Medical Navigation Support, VdV Soundboard will handle that information consistently with the limited authorization provided in Section 2 and applicable privacy requirements.

*If you have questions about privacy, information-sharing, or whether outside professional advice is needed, please raise those questions before services begin.*

| **Client name (printed)** | **Signature** | **Date** |
|---|---|---|

## 2. Medical Navigation Support and Information-Sharing Authorization

*Complete this section only if you are requesting Medical Navigation Support.*

### A. Client / Patient Information

| | |
|---|---|
| **Client / patient full name** | |
| **Date of birth (MM/DD/YYYY)** | |
| **Are you the patient or acting on behalf of the patient?** | |
| **If acting on behalf of the patient, describe your relationship / authority** | |

☐ Patient ☐ Family member ☐ Legal guardian / POA ☐ Other: _____

### B. Medical Details

**1. Medical condition or reason for navigation support**

**2. Current treatments or medications (if known)**

**3. Healthcare providers / facilities (name, specialty, contact information)**

**4. Upcoming appointments (date, location, purpose)**

## C. Communication and Coordination

**Preferred communication method for medical updates (check all that apply)**

☐ Phone ☐ Text

☐ Email ☐ Video call

**Will travel support be needed for specialized or distant treatment?**

☐ Yes ☐ No

**If yes, list any known dates, treatment locations, or travel details**

**Who may receive updates about appointments, travel, or treatment coordination?**

☐ Patient ☐ Family member(s) ☐ Legal guardian / POA ☐ Other: _____

## D. Limited Authorization for Information-Sharing

- I authorize Robert van der Vijver to assist with medical navigation support related to scheduling, appointment coordination, note-taking, follow-up understanding, and communication support.
- If I choose, I also authorize limited receipt and sharing of relevant appointment details, provider instructions, treatment information, and related health information for the purpose of supporting communication and coordination connected to Medical Navigation Support.
- This authorization applies only to the providers or facilities identified below and remains in effect until services end or until the date listed below, whichever comes first. I understand that I may revoke this authorization at any time by giving written notice. Revocation will not affect information already shared before the notice was received.
- I understand that Robert van der Vijver is not a licensed health professional and does not provide medical advice, diagnosis, or treatment. I should continue to rely on licensed healthcare providers for all medical decisions.

**Names of healthcare providers / facilities covered by this authorization**

| | |
|---|---|
| **Expiration date of authorization (if any)** | |
| **Best contact person for coordination (if different from client)** | |

| **Client / patient name (printed)** | **Signature** | **Date** |
|---|---|---|

**If signed by someone other than the patient, complete below**

| | |
|---|---|
| **Authorized representative name (printed)** | |
| **Relationship to patient / authority to sign** | |
| **Representative signature / date** | |

## 3. Criminal Justice and Juvenile Family Support Authorization

*Complete this section only if support involves a criminal justice matter, juvenile matter, or family support connected to those issues.*

## A. Person Receiving Support

☐ Adult client ☐ Parent / guardian seeking support ☐ Minor / juvenile support requested

| | |
|---|---|
| **Name of person directly involved** | |
| **Date of birth (if needed / if minor)** | |
| **If minor, name of parent / guardian / responsible adult** | |
| **Relationship to the person receiving support** | |

## B. Matter Information

| | |
|---|---|
| **County / jurisdiction (if known)** | |
| **Case or referral number (if known)** | |
| **Attorney / public defender / probation contact (if any)** | |

**Briefly describe the situation and the kind of support requested**

## C. Communication and Family Coordination

**Who should be kept informed, and what type of communication support is needed?**

☐ Help understanding the process

☐ Help organizing questions or information

☐ Help with family communication

☐ Juvenile / parent support

☐ General sounding board support

## D. Boundaries and Confidentiality

- This service is not therapy, legal representation, or crisis intervention. It is practical support, communication help, and a judgment-free sounding board.
- Information shared will be handled with care and discretion. However, if there is a serious risk of harm to the client, a minor, or another person, or if disclosure is otherwise required by law, Robert van der Vijver may need to notify appropriate parties or authorities.
- When a minor is involved, the responsible adult authorizing services understands that support conversations may remain private to the extent appropriate, while safety concerns and legally required disclosures will be handled responsibly.

## E. Authorization

I authorize Robert van der Vijver to provide Criminal Justice and Juvenile Family Support services consistent with the limits described in this form. I understand that I may withdraw consent at any time by providing written notice.

| Responsible adult / client name (printed) | Signature | Date |
|---|---|---|

*Emergency Note: VdV Soundboard is not an emergency service. If you are experiencing an emergency, a mental health crisis, or thoughts of self-harm, call 911 or 988 immediately.*