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COUNSELING

This paperwork is to be filled out separately from your partner and brought with you to your first appointment. In order for our work together to be the most productive it's important to answer the questions below as openly and honestly as possible. Please note that you will be asked to talk about your answers in session, but your partner will not be shown this form.

Client Name: _____ **Today's Date:**_____

Name of Partner:_____

Relationship Status: (check all that apply)

- ☐ Married
- ☐ Dating
- ☐ Separated
- ☐ Cohabitating
- ☐ Divorced
- ☐ Living Separately

Length of time in current relationship:_____

What is your overall satisfaction with your relationship on a scale of 0 to 10?

0 1 2 3 4 5 6 7 8 9 10

(Extremely Unsatisfied) (Extremely Satisfied)

What is the primary reason you're seeking couples therapy at this time?_____

_____

_____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern	***Frequency***
☐ No Concern	☐ No Occurrence
☐ Little Concern	☐ Rarely Occurs
☐ Moderate Concern	☐ Sometimes Occurs
☐ Serious Concern	☐ Frequently Occurs
☐ Very Serious Concern	☐ Nearly Always Occurs

What do you hope to accomplish through counseling?_____

_____

_____

What have you already done to try deal with the difficulties?_____

_____

_____

Brandy I. Torretta, M.S., Registered Mental Health Counselor Intern
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What do you believe your biggest *strengths* are as a couple?_____

_____

What's going *right* in your relationship?_____

_____

_____

What do you like most about your partner?_____

_____

_____

How happy are you in your relationship on a scale of 0 to 10?

0 1 2 3 4 5 6 7 8 9 10

(Extremely Unhappy) (Extremely Happy)

Please make at least one suggestion as to something you can do personally to improve your relationship regardless of what your partner does?_____

_____

_____

Have you received prior couples counseling related to any of the above problems? ☐ Yes ☐ No

If yes, please explain when, with whom, the length of treatment, problems treated, and the outcome:_____

_____

_____

_____

Have either you or your partner received *individual* counseling before? ☐ Yes ☐ No

If yes, please give a brief summary of concerns that were addressed:_____

_____

_____

_____

Do either of you or your partner drink alcohol and/or take drugs to intoxication? ☐ Yes ☐ No

If yes for either of you, please indicate who, how often, what substances are being used, and how problematic you believe this is in your relationship:_____

_____

_____

Has there been any type of abuse in your relationship? ☐ Yes ☐ No If yes, please explain:_____

_____

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Has either of you threatened to separate or divorce (if married) as a result of the current relationship problem(s)? ☐ Yes ☐ No If yes, who? ☐ Me ☐ My Partner ☐ Both of Us

Do you perceive that either you or your partner has withdrawn from the relationship? ☐ Yes ☐ No
If yes, which of you has withdrawn? ☐ Me ☐ My Partner ☐ Both of Us

How satisfied are you with your *physical intimacy* during the last month?

0 1 2 3 4 5 6 7 8 9 10
(Extremely Unsatisfied) (Extremely Satisfied)

How satisfied are you with your *emotional intimacy* during the last month?

0 1 2 3 4 5 6 7 8 9 10
(Extremely Unsatisfied) (Extremely Satisfied)

What is your current level of stress *overall*?

0 1 2 3 4 5 6 7 8 9 10
(No Stress) (High Stress)

What is your current level of stress *in the relationship*?

0 1 2 3 4 5 6 7 8 9 10
(No Stress) (High Stress)

Rank in order the top three concerns you have in the relationship and with your partner, with #1 being the most problematic:

1. _____
2. _____
3. _____

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Notice of Privacy Practices (HIPPA)

As a licensed mental health provider, I am required by federal and state laws to protect your privacy. The **Health Information Portability & Accountability Act (HIPPA)** establishes limits on how our health information may be used and shared and how it must be protected. When Florida laws protecting your health records are more restrictive than federal laws, I must abide by the Florida laws. The following *Notice of Privacy Practices* will tell you about the ways I may use and share mental health information about you. It will also describe your rights and my obligations regarding the use and disclosure of your mental health information.

My Pledge to You Regarding Your Mental Health Information
The privacy of your mental health information is important to me. I create a record of the treatment you receive from me to provide you with quality treatment and to comply with certain legal requirements. I understand this information is personal and I am committed to protecting it.

This Notice of My Privacy Practices Describes:

- How and to what extent the privacy of your Protected Health Information is guaranteed.
- How your Protected Health Information may be used and disclosed.
- How you may access portions of your Protected Health Information and the procedure for doing so.

Your Protected Health Information (PHI)
Your PHI includes any *individually identifiable information* created or received about you. Specifically, it includes identification of symptoms, diagnosis, medications, treatment, appointment dates and times, session summaries, and payment history.

Use and Disclosure of Your Protected Health Information (PHI)

- I will not share with your managed care company (insurance) or Employee Assistance Program (EAP) the PHI required to obtain authorization to treat you and to bill for your treatment services.
- I will not share your PHI with another therapist or treatment facility.
- I will not share your PHI with any other individual, including family members, except in the case of minor children.
- I am required by law to report abuse and/or neglect of children, elderly, and persons with disabilities to the proper authorities. This report may, of necessity, include your PHI.
- I am required by law to take immediate action, including the release of your PHI, if I believe that you or someone else is at imminent risk of harm.
- I may share your PHI with my Clinical Supervisor, Misty Lee Fenton, LMHC whom has agreed to abide by the terms of my Notice of Privacy Practices.
- I may disclose your PHI in response to a court order, subpoena, warrant, summons, or similar legal process.
- I may disclose your PHI as required by federal, state, or local law.

Your Privacy Rights

- With the exception of the purposes listed above, you have the **right to decide** if your PHI is given out to a third party and to specify what information is given. You do this by completing and signed the **Authorization for Release of Confidential Information** form provided by your counselor upon request. You may revoke this consent at any time.

- You have the **right to review** and get copies of your PHI with certain exceptions. This request must be in writing and there may be charges for copies and postage.
- You may **request that corrections or additions be made** to your PHI if you believe that there is an error or a significant omission.
- You may **request additional restrictions** on y use or disclosure of your PHI.
- You may **request that I use an alternative way to communicate with you in a confidential manner** or communicate with you at an alternative location about your PHI.
- You may **obtain a list of the times I have disclosed your health information** for purposes other than treatment, payment, healthcare operations, and other specified exceptions.
- You will **receive a paper copy of my Notice of Privacy Practices** for your records.
- You have the **right to file a written complaint** with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

My Legal Duty
As a licensed mental health provider, I am required to abide by the terms of this notice. However, I reserve the right to change my privacy practices and the terms of this notice at any time provided the changes are permitted by law or meet any new requirement implemented by law for the benefit of your PHI. Before I make any important changes to my privacy practices, I will revise this notice and make the new notice available to you on your first visit following revisions. Any changes in my privacy practices and the new terms of this notice will be effective form the date of the revision forward for all mental health information I keep. You are entitled to receive a copy of the most current notice and may obtain it at any time by request.

By signing below, I acknowledge that I have been given a copy of this Notice of Privacy Practices and have read all of the above information. I acknowledge that all questions regarding my privacy have been answered in an acceptable manner.

_____ _____
Signature **Date**

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Office Policies and Client Information

Client Expectations of the Counseling Process and Outcomes
Your goals and expectations are more likely to be met when you understand the nature and limitations of counseling. Generally, counseling is most useful in helping people improve their self-awareness to allow positive change in their life. Counseling provides a safe and confidential atmosphere to examine the way you choose to process information and to help you expand your ability to react to the world around you. Most people experience improvement or resolution of their concerns that brought them to counseling. However, there are no guarantees and there may be risks. For example, counseling could open up new level of awareness that could cause discomfort. We will work together as a team towards your personal counseling goals, but *you* determine the nature and amount of change you wish to make. ***Please be advised I do not keep secrets between partners and any information you choose to share may become part of our sessions if I believe it will benefit your therapy goals.***

Office Visits
Hourly rates are based on a 50-minute session, which allows for necessary documentation time. At times, sessions may be slightly longer or shorter based on the therapist's judgement to maximize the quality of the session. After our initial session, we will determine together the frequency and availability of continued sessions. While the length of therapy varies from client to client, it is my aim to work together until resolution is found. It is your right as a client to terminate therapy at any time or to seek a second opinion from another therapist. Payments are to be made at the end of each session and accepted forms of payment include cash, check, or debit/credit card. When requested, documentation can be provided to assist you in seeking reimbursement from your insurance provider.

Cancelation Policy
Please notify me of appointment cancelations at least 24 hours in advance of your appointment time to avoid a late cancelation/missed appointment fee. You will be charged your regular session fee for no-show and cancelations made after 24 hours. However, you will not be charged in cases of emergency situations. As a courtesy, an appointment reminder will be sent to you the day before your appointment.

Methods of Contact
On occasion, there might be a need to have contact outside a normal session. To preserve your confidentiality, I request that email or text be used only to schedule or confirm appointment dates/times as I cannot assume responsibility for the security maintenance of electronic transmissions. In times of immediate crisis or emergency, I may be contacted by phone. If it is outside normal business hours of 9 AM to 7 PM, please leave a message ad I will return your call as soon as possible. ***If you have a life-threatening emergency, please call 911 or the Tampa Bay Crisis Center at 211 for immediate assistance.***

Confidentiality
The notion of confidentiality is paramount in counseling. Everything disclosed between the therapist and client is confidential, unless authorized by the client or required by law. A client may authorize the release of confidential information by signing an *Authorization for Release of Confidential Information* form, which will be provided to you upon request. I will not release any confidential information without this written authorization, unless such release is otherwise authorized or required by law. ***The law requires mandated release of confidential information in the case of child abuse or neglect, if the client has intent to harm himself/herself or others, or in the case of a court subpoena.*** For additional details on how your information may be used and our rights to our health care information, please refer to the Notice of Privacy Practices that you received.

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By signing below, I acknowledge I have read the preceding information, understand my rights as a client and all general policies, and acknowledge I have received a copy of this document for my records.

_____ _____

Signature **Date**

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Payment Information

Your counselor requires a card to be kept on file for your session payments. Your card will also be automatically charged for any ***missed appointments*** *and* ***cancelations made less than 24 hours in advance***, and a ***$35 fee for any declined payments***. By signing below, you consent to the policies above and authorize your card on file to be charged.

PLEASE WRITE CLEARLY

Name on Card:_____ Card #:_____-_____-_____-_____

Exp. Date:_____/_____ CVC Code:_____ Billing Zip Code:_____

Signature:_____

Best Email for Receipts:_____