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Minor Intake Form

A thorough assessment is important because it can provide your counselor with helpful information about your child's background that could assist in his/her treatment. In an effort to ensure your counselor can spend in-session time on what is most important to you instead of collecting this information, we ask that you complete this packet in it's entirety and bring it with you to your child's first appointment. Please ***read carefully*** as there is important information about policies, your rights, and consent to treatment.

Child's Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Is the child adopted? Y N If yes, what age?_____

Parent/Guardian's Name 1:_____Relation:_____

Parent/Guardian's Name 2:_____Relation:_____

Phone: (h)_____ (c)_____

Address:_____

Email:_____

Emergency Contact:_____ Best Phone #:_____

Referral Source:_____

What are you seeking counseling for at this time?_____

_____

_____

Is the reason you're seeking counseling at this time related to a custody case? If yes, please explain:_____

_____

_____

_____

Does your child have any previous mental health diagnosis? If yes, what is the diagnosis and what age were they diagnosed?_____

_____

_____

What do you hope to accomplish or change by seeking counseling at this time?_____

_____

_____

_____

Brandy I. Torretta, M.S., Registered Mental Health Counselor Intern
FL License # IMH16938
Phone: 813-402-8631 | Email: brandytorretta@gmail.com | www.inspirecounselingtampa.com
4100 West Kennedy Blvd., Ste. 214
Tampa, FL 33609

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Please describe any symptoms your child is experiencing (*intensity 1-10; 1 being low and 10 being extreme*):

Main Symptoms & Behaviors	**Intensity (*rate 1-10*)**	**How often do you notice symptoms/behaviors occurring?**	**How long do symptoms/behaviors last?**

List any major life changes, trauma, surgeries, serious injuries, or illnesses your child has experienced and age they occurred:

- _____
- _____
- _____
- _____
- _____

Please check all that apply or have applied to your child or your family at any point in their life:

☐ Abuse (*sexual, physical, mental, emotional*)
☐ Acting Out
☐ Divorce
☐ Bedwetting
☐ Bullying/ Being Bullied
☐ Nail biting
☐ Nightmares
☐ Academic Problems
☐ Peer Conflict
☐ Eating/Appetite Problems
☐ Low Self-Esteem or Insecurity
☐ Lying
☐ Aggressive Behavior
☐ Fire Setting
☐ Cruelty Toward Animals
☐ Intense Anger or Rage
☐ Self-Harm Behaviors
☐ Running Away from Home
☐ Mood Swings
☐ Sexual Concerns
☐ Fear
☐ Panic Attacks
☐ Migraines or Chronic Headaches
☐ Grief/Loss
☐ Excessive Worrying
☐ Shyness
☐ Physical Abuse
☐ Depression
☐ Anxiety
☐ Stress
☐ Temper Tantrums
☐ Excessive Crying
☐ Sleep Problems
☐ Suicidal Talk/Attempts
☐ Homicidal Talk/Attempts
☐ Family Conflict in Home
☐ Domestic Violence
☐ Withdrawn
☐ Attention Problems
☐ Fighting

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Has your child ever received psychological, psychiatric, drug or alcohol treatment or counseling services before?
If yes, please explain:_____

_____

_____

_____

Is your child currently taking any medications for a mental health, psychiatric, emotional, or behavioral problems? If yes, please explain:_____

_____

_____

_____

Education Information

Name of School:_____

Current Grade Level:_____ Special Classes or Curriculum:_____

Positive elements of school experience (favorite subjects, academic progress, supportive teachers, peer relationships):

_____

_____

Negative elements of school experience (academic difficulties, behavioral issues, peer/teacher issues):_____

_____

_____

Is your child involved in extra curricula activities outside of school? If so, please list:_____

_____

Health Data

How would your describe your child's daily mood and energy levels?_____

_____

Does your child have any issues related to sleep or bedtime?_____

_____

How would you describe your child's overall health?_____

_____

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To your knowledge, does your child use any substances (alcohol, cigarettes, illegal drugs, steroids, over the counter drugs, marijuana, etc.)_____

_____

List all medical providers your child is currently seeing (physician, psychologist, nutritionist, etc.):_____

_____

_____

List all current medications your child is currently taking (include dosage levels and reasons):_____

_____

_____

_____

Family Relationship Information

Does your family have a history of any medical or mental health conditions? If yes, please explain:_____

_____

_____

_____

Has your child experienced any significant losses or stressors? If yes, please explain:_____

_____

_____

_____

Briefly describe your child's level of social support and peer relationships:_____

_____

_____

How would you describe your child's relationships with his/her family?_____

_____

_____

Please list your child's personal strengths:_____

_____

_____

Briefly describe your child's temperament:_____

_____

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What are your biggest strengths as a family?_____

_____

_____

What are your expectations for therapy?_____

_____

_____

Is there anything else you think would be important for me to know for successful treatment? If so, please explain:

_____

_____

_____

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Policies and Consent to Treatment

PLEASE INITIAL TO INDICATE YOU HAVE READ OF UNDERSTAND EACH POLICY

_____**Financial Policy**: Full payment is due at time of service (unless prior arrangements have been made). Please note that your Brandy Torretta ***does not*** accept insurance at this time and you are solely responsible for making payments in a timely manner. You will be charged a ***$35 fee for any declined payments in addition to your full session payment***. Unpaid balances may be turned over for collection or reported to the state's attorney's office. Understanding this policy is important to our relationship. Please feel free to ask if you have any questions about this policy.

_____**Cancellation Policy**: Please help me serve you and others better by keeping your scheduled appointments. If you need to reschedule or cancel an appointment, please do so 24 hours in advance to avoid being charged your full session fee. ***You will be charged your full session fee for any missed appointments and cancellations made after 24 hours.*** The 24-hour cancelation policy allows me to offer the appointment to another client who may need to be seen. Brandy Torretta reserves the right to require prepayment in order to schedule subsequent appointments.

_____**Confidentiality**: Federal and State laws protect your confidentiality (see 42 U.S.C 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Brandy Torretta will not share information with any person outside of Inspire Counseling, LLC without your written permission, except as required by law. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you to access your file and protect the electronic transfer of information.

_____**Limits to Confidentiality**: Federal regulations do not protect from disclosure of information related to clients' involvement in a crime against property or person(s). Brandy Torretta is required under Florida state law to report suspected abuse of a child, elderly person, or an individual(s) with a disability. Brandy Torretta may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Brandy Torretta has the option of breeching confidentiality if you report a specific plan or intent to cause life threatening bodily harm to yourself or another person(s).

_____**Consent to Treatment**: I am voluntarily seeking outpatient counseling from Brandy Torretta at Inspire Counseling, LLC. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy at any time. I am strongly encouraged to discuss my treatment plan and progress in treatment with Brandy Torretta. Brandy Torretta will also discuss alternative treatments as well as the benefits and risks associated with therapy. ***With my signature below, I acknowledge that I have read, understand, and agree to all of the information above and consent to treatment from Brandy Torretta at Inspire Counseling, LLC.*** I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented at Inspire Counseling, LLC. Please note that individual counseling sessions are 50 minutes in length. Please note that Brandy Torretta does not provide emergency services and you are to call 911 for medical or mental health crisis/emergencies.

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Notice of Privacy Practices

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.

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- 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.

I,_____acknowledge that I have read the preceding information and have kept a copy of this notice for my personal records. I acknowledge that all questions regarding my privacy have been answered in an acceptable manner.

_____ _____
Parent/Guardian Signature **Date**

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Client Policies and 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.

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. **Please notify me of appointment cancelations at least 24 hours in advance of your appointment time to avoid a late cancelation/missed appointment fee. However, you will not be charged in cases of emergency situations.**

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.

I,_____have read the preceding information, understand my rights as a client and all general policies, and acknowledge I have kept a copy of this notice for my personal records.

_____ _____
Parent/Guardian 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:_____