



## **What to Expect When You Bring Your Teen to Therapy**

If you're bringing your teen in for therapy, it's likely you're concerned or worried that something might be wrong based on his or her behavior. Teens have not yet developed the skills needed to understand and communicate how they're feeling so it's common for them to not tell you what's going on inside. Having a neutral space for your teen to explore and express how they're feeling is the first step in getting to the root of the problem and helping them in the way *they* need.

When I see your teen for therapy, I generally regard the family unit as the client because parents hold MOST of the power when it comes to creating change. More often than not, teens' behaviors are in response to something going on within the family. If you're looking for a therapist to change your teen's behaviors and you're unwilling to participate in our sessions and make necessary changes within yourself, I am not the right therapist for you.

To try to gain control of out-of-control situations, teens will often rebel and act with "defiance". However, it's important you understand that ALL behavior is a form of communication and your teen is trying to communicate something with underdeveloped cognitive, emotional, and communication skills. This is where I can help. I tell my teens from the beginning that our sessions are confidential, within limits of course, and I'm there to help them get clear about what it is that needs to change so they can feel better. I also express that part of my job is to help their parents understand what *they* can personally do better to help. I often find that teens have a very valid reason for feeling the way they do, and a part of the problem is they don't feel heard. Therefore, part of my job is to help parents understand their teen's behaviors better so they can get to the root of the problem and make adjustments to improve the situation.

My goal is to help you and your teen understand each other better and offer strategies and solutions to get you both back on track in your relationship. I teach my parents how to *connect* before they *correct* because without connection teens won't open up, which prevents us from intervening and guiding them toward healthy choices. Research has shown time and again it's the *quality* of the relationship we have with our teens that is the *best* agent of positive change.

I'm honored that you're trusting me to work with you and your teen and I look forward to helping you both create the changes you'd like to see!



**Teen 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 its 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? \_\_\_\_\_

\_\_\_\_\_

Are you (*parent/parents*) willing to be an active participant in your child's treatment? Y N

What are your biggest concerns with regards to your child: \_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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:

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

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 History**

How would you 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? \_\_\_\_\_

\_\_\_\_\_

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.): \_\_\_\_\_

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

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### **Family Relationship History**

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

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

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

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

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Please list your child's personal strengths: \_\_\_\_\_

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Briefly describe your child's temperament: \_\_\_\_\_

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What are your biggest strengths as a family? \_\_\_\_\_

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What are your expectations for therapy? \_\_\_\_\_



# INSPIRE

COUNSELING

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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 cancellation 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 breaching 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.



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

\_\_\_\_\_

**Parent/Guardian Signature**

\_\_\_\_\_

**Date**



## 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 and 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.

***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 kept a copy of this notice for my personal records.***

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



### Payment Information

Your therapist requires a card to be kept on file for 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 after each session.

**PLEASE WRITE CLEARLY**

Name on Card: \_\_\_\_\_ Card #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Exp. Date: \_\_\_\_/\_\_\_\_ CVC Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Best Email for Receipts: \_\_\_\_\_

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\_\_\_\_\_  
**Brandy Torretta, M.S., LMHC**

\_\_\_\_\_  
**Date**