

Adolescent Intake Packet



STAY AND TALK
LLC

Tyler Zenz, MA, LAC, GC-C
Licensed Addiction Counselor
Certified Grief Counselor
Certified Peer Support Specialist

Professional Disclosure & Informed Consent

Counselor Information:

Name: Tyler Zenz

Professional Licensures

Licensed Addiction Counselor (LAC) – South Dakota

Licensed Alcohol and Drug Counselor (LADC) – Minnesota

Substance Abuse Counselor (SAC) – Wisconsin

Certifications

Certified Grief Counselor

Certified Peer Support Specialist

Special Trainings

Moral Reconciliation Therapy

Motivational Interviewing

Cognitive Behavioral Therapy

Stay and Talk provides counseling and support related to:

- Substance use and recovery
- Grief and loss
- Trauma
- Mental health concerns
- Stress and life transitions
- Personal growth and emotional wellness

Nature of Counseling

Counseling is a collaborative process in which clients explore personal concerns, develop insight, and work toward healthier coping strategies.

Counseling may involve discussing difficult emotions, past experiences, relationships, and behavioral patterns.

While many clients experience meaningful improvement, specific outcomes cannot be guaranteed.

Voluntary Participation

Participation in services is voluntary.

Clients may discontinue services at any time for any reason. The counselor may also recommend

referral to another provider if services fall outside the scope of practice or if another provider may better meet the client's needs.

Confidentiality

Information shared during counseling is confidential except when disclosure is required by law. Situations where confidentiality may be broken include:

- Risk of harm to yourself
- Risk of harm to others
- Suspected child abuse or neglect
- Court orders or legal requirements

If possible, confidentiality concerns will be discussed before disclosure occurs.

Fees

Stay and Talk currently provides free counseling services. Please see below for further details.

Emergency Situations

Stay and Talk does not provide crisis services.

If you are experiencing a crisis or mental health emergency, please contact:

911

988 Suicide & Crisis Lifeline

Local emergency services

Licensure and Scope of Practice

Due to licensing regulations that vary by state, I am only able to provide formal clinical services, including substance use assessments and counseling, in states where I currently hold an active professional license. If you reside in a state where I am not licensed, I am unable to provide clinical services; however, I can offer peer support and general guidance based on my experience in recovery and behavioral health. Peer support services do not constitute clinical treatment or therapy and are intended to provide encouragement, shared experience, and support.

Please note that I am unable to provide mental health diagnoses, medication management, or guidance regarding psychotropic medications.

Eligibility

To avoid conflict of interest, please disclose any current treatment services you are receiving so that coordination and appropriateness of care can be considered.

Legal Custody and Decision-Making Authority

Because counseling services are being provided to a minor, the counselor must verify who has legal authority to consent to treatment.

Who currently has legal custody of the minor?

- Both parents
- Mother
- Father
- Legal guardian
- Foster parent
- Other: _____

Are there any court orders, custody agreements, or legal documents that affect who can make medical or counseling decisions for the minor?

- Yes
- No

If yes, please describe or provide documentation:

The signing parent or guardian confirms that they have the legal authority to consent to counseling services for this minor.

Parent / Guardian Name: _____

Signature: _____

Date: _____

Authorization to Coordinate Care

In some cases, it may be helpful for the counselor to communicate with other professionals involved in the minor's care (such as physicians, school staff, or other treatment providers) in order to coordinate services and support the minor's wellbeing.

Authorization is voluntary and may be revoked at any time in writing.

I authorize Stay and Talk, LLC to communicate with the following individuals or organizations for the purpose of coordinating care:

Name / Organization: _____

Relationship to minor: _____

Name / Organization: _____

Relationship to minor: _____

Parent/Guardian Signature: _____

Date: _____

Insurance and Billing Notice

Stay and Talk, LLC currently provides counseling services free of charge.

Stay and Talk does not bill insurance and does not provide documentation for insurance reimbursement.

Clients and families should be aware that counseling services provided through Stay and Talk are not submitted to insurance companies and are not part of an insurance billing system.

This is subject to change in the future; however, individuals will be informed **no less than 6 months in advance** prior to any changes being made. Even if Stay and Talk begins to charge for services, you will continue to receive services free of charge for six months from the day you were notified.

Adolescent Intake Information Form

Client Information

Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Who do you live with: _____

School: _____

Grade: _____

Parent / Guardian Information

Name: _____

Relationship to adolescent: _____

Phone Number: _____

Email: _____

Emergency Contact (*if different*): _____

Phone: _____

Reason for Seeking Support

Please briefly describe the concerns that led you to seek counseling:

Mental Health / Behavioral Concerns

Please check any that apply:

- Anxiety
- Depression
- Substance use concerns
- Behavioral issues
- School problems
- Grief or loss
- Trauma
- Family conflict
- Social difficulties
- Other: _____

Previous or Current Counseling/Treatment

- Yes
- No

If yes, please describe:

Grief and Loss History

Because Stay and Talk also provides grief counseling, please indicate if you have experienced any significant losses:

- Death of a loved one
- Divorce or relationship loss
- Loss related to addiction or recovery
- Loss of employment or major life change
- Traumatic loss
- Other: _____

Substance Use History *(If Applicable)*

Please indicate substances currently used or previously used:

- Alcohol
- Cannabis / Marijuana
- Stimulants (methamphetamine, cocaine, etc.)
- Opioids
- Hallucinogens
- Other: _____

Date of last use: _____

Safety Concerns

Have you ever experienced:

Thoughts of self-harm or suicide?

Yes No

Self-harm behaviors?

Yes No

If yes, please explain:

Telehealth Consent Form *(If Applicable)*

Telehealth counseling involves providing counseling services through secure video, phone, or other electronic communication methods. This allows clients to participate in counseling remotely when in-person sessions are not available or preferred. However, technology failures or confidentiality risks may occur despite efforts to protect privacy.

Telehealth is not appropriate for emergencies.

Benefits of Telehealth

- Increased access to counseling services
- Convenience and flexibility
- Reduced travel time

Risks of Telehealth

- Technology failures or interruptions
- Possible security risks despite efforts to protect confidentiality
- Reduced ability to respond immediately in emergencies

Confidentiality

Telehealth sessions will be conducted using platforms designed to protect privacy whenever possible. However, clients should understand that electronic communication carries some inherent risks. Clients are encouraged to participate in telehealth sessions from a private location to protect their own confidentiality.

Emergency Situations

Telehealth counseling is not appropriate for emergency or crisis situations.

If a mental health emergency occurs, please contact:

911

988 Suicide & Crisis Lifeline

Local emergency services

Client Responsibilities

Clients agree to:

- Provide accurate contact information
- Ensure a private location for sessions
- Inform the counselor if technology issues occur

Consent for Telehealth Services

By signing below, I acknowledge that I understand the nature of telehealth services and consent to receiving services through telehealth when appropriate.

If telehealth services are used, please provide the primary address where the minor will typically be located during sessions:

Address: _____

City/State/Zip: _____

This information helps emergency responders locate the client if urgent assistance is needed.

Telehealth acknowledgement

Client Name _____

Signature _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date _____

HIPAA Privacy Acknowledgment

Purpose of This Notice

This notice briefly describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

Stay and Talk, LLC is committed to protecting the privacy and confidentiality of your personal and health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Uses and Disclosures of Your Information

Your protected health information may be used or shared for the following purposes:

- Treatment
- Information may be used to provide counseling services, coordinate care, and support treatment planning.
- Legal Requirements

Information may be disclosed when required by law, including:

- Suspected child abuse or neglect
- Threats of harm to yourself or others
- Court orders or subpoenas

Mandated Reporting Notice

As a licensed counselor, I am a mandated reporter under state law. This means that if there is reasonable suspicion of child abuse, child neglect, abuse of a vulnerable adult, or imminent danger to the client or others, I am legally required to report this information to the appropriate authorities.

Emergencies

Information may be shared when necessary to prevent serious harm or in a medical emergency.

Administrative Purposes

Basic information may be used for scheduling, record keeping, and internal practice operations.

Your Rights Regarding Your Information

You have the right to file a complaint if you believe your privacy rights have been violated. Requests should be made in writing.

Confidentiality of Substance Use Treatment Records

Federal law and regulations (42 CFR Part 2) protect the confidentiality of substance use disorder

treatment records. Information identifying a client as receiving substance use counseling services may not be disclosed without the client's written consent except as permitted by federal law.

This means that information related to substance use treatment generally cannot be shared with others, including family members, schools, employers, or other providers, without written authorization from the client or their legal guardian, unless an exception under the law applies.

These protections are in addition to the privacy protections provided under HIPAA.

If you have questions about these confidentiality protections, please reach out via phone or email.

If you believe your privacy rights have been violated, you may contact:

Stay and Talk, LLC

Tyler Zenz, MA, LAC, GC-C

320 S 2nd Ave Ste 1906

Sioux Falls, SD 57104

Phone: 605-929-4900

Email: Tyler@stayandtalk.com

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Filing a complaint will not affect your access to services.

Acknowledgment of Receipt

I acknowledge that I have received and reviewed the Notice of Privacy Practices.

Client Name: _____

Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date _____

Adolescent Client Confidentiality Agreement

What Confidentiality Means

When you talk with your counselor, what you say is usually private. This means your counselor will not share what you talk about with others without permission.

This privacy helps create a safe space where you can talk openly about things that may be difficult, confusing, or stressful.

When Information May Be Shared

There are some situations where the counselor must share information in order to keep people safe or follow the law.

These situations include:

- If you say you plan to hurt yourself
- If you say you plan to hurt someone else
- If there is suspected abuse or neglect of a child or vulnerable adult
- If a court requires records or testimony

In these cases, your counselor may need to contact parents, guardians, or appropriate authorities.

What Parents or Guardians May Be Told

Your parent or guardian may receive general information such as:

- Attendance
- Overall progress
- Safety concerns

However, the specific details of what you talk about in counseling may remain private unless safety is involved.

Role in Counseling

Counseling works best when you:

- Are honest
- Ask questions
- Share what you feel comfortable sharing
- Let the counselor know if something feels uncomfortable

You are always allowed to ask questions about counseling or confidentiality.

Adolescent Agreement

I understand how confidentiality works in counseling and understand the situations where information may need to be shared.

Client Name: _____

Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date _____

Parent Communication Agreement

Communication with parents/guardians

Counseling with minors works best when there is a balance between privacy and parental involvement. Parents or guardians may receive updates regarding:

- Attendance
- Participation in treatment
- General progress
- Safety concerns

However, the counselor may keep some information shared by the minor confidential in order to maintain trust and encourage open communication.

Safety Exceptions

If the counselor believes the minor is:

- At risk of harming themselves
- At risk of harming others
- Being abused or neglected

The counselor may immediately notify parents/guardians or appropriate authorities.

Parent Support

Parents are encouraged to:

- Support the counseling process
- Encourage open communication
- Respect the minor's privacy when appropriate

Parent/guardian acknowledgement

I understand the balance between confidentiality and parental involvement in my child's counseling.

Client Name: _____

Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date _____

Parent Participation Agreement

Counseling with adolescents is most effective when there is a balance between parental involvement and the adolescent's ability to speak openly during sessions. In order to build trust and encourage honest communication, some information shared during counseling sessions may remain private between the counselor and the adolescent.

Parents or guardians play an important and supportive role in the counseling process. The counselor may provide parents or guardians with general information regarding:

- Attendance and participation
- Overall progress toward counseling goals
- Recommendations for support at home
- Safety concerns

However, specific details of conversations during counseling sessions may remain confidential unless one of the following situations occurs:

- The adolescent expresses intent to harm themselves
- The adolescent expresses intent to harm another person
- There is suspected abuse or neglect
- Disclosure is otherwise required by law

In situations involving safety concerns, the counselor will take appropriate steps to protect the adolescent and others, which may include notifying parents, guardians, or appropriate authorities.

Parents and guardians are encouraged to support the counseling process by:

- Encouraging open communication
- Respecting appropriate therapeutic privacy
- Supporting treatment recommendations
- Communicating concerns directly with the counselor when needed

This agreement helps create a safe and supportive counseling environment while still allowing parents or guardians to remain appropriately involved in their child's care.

Parent/Guardian Acknowledgment

I understand the importance of balancing parental involvement with appropriate confidentiality in adolescent counseling. I agree to respect the counseling process and support my child's participation in services.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Adolescent Name: _____

Adolescent Signature: _____

Date: _____

Acknowledgment of Counseling Policies and Consent for Services

By signing below, I acknowledge that I have received and reviewed the intake packet for Stay and Talk, LLC. I understand the information provided regarding counseling services, confidentiality, policies, and procedures.

I consent to participate in counseling services and understand the limits of confidentiality as explained in this packet.

I also acknowledge that I have had the opportunity to ask questions and receive clarification regarding any part of these policies.

Client Name: _____

Client Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____