D.J. DIEBOLD, CAC, LISAC
DIEBOLD BEHAVIORAL COUNSELING
9375 E. Shea Blvd. Suite 278 Scottsdale, AZ 85260

(480) 650-1020 Fax (480) 386-7011

Last Name of Client: _____ First Name: _____

Client Date of Birth: _____ Age___ Gender: M F (Circle) SSN_____

Marital Status: ____Married ____Single ____Partner ____Separated ____Divorced ____Widowed

Home Address: _____

City_____ State _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____(relationship_____) Phone: _____

May I contact any of the above numbers to reach you or leave a message/voice mail? Yes No

Billing Address (if different) _____

City_____ State_____ Zip Code_____

Employer Name and Address _____

_____

Who Referred You? _____May I send a Referral Thank You to them? Yes No

Client's Spouse, Partner or Guardian _____

Street_____

City _____ State _____ Zip Code _____

Home Phone_____ Work Phone _____ Cell _____

May I contact any of the above numbers to reach you or leave a message/voice mail? Yes No

Relationship to Client _____

Birth date_____ Social Security Number _____

Employer Name and Address_____

The below is for Insurance Purposes

Insurance Company Name _____ Phone _____

Insured Party's Full Name _____ Relationship to Client _____

Group Name_____ Group ID No. _____

Do you have any other insurance company that has these benefits? ___ Yes ___ No

Please provide your insurance identification card for copying.

I authorize the above release by mail, internet, in-person, telephone, cellular phone or fax any protected health/mental health or other information necessary to process insurance claims or treatment reports or disability claim/evaluation reports on my behalf.

I hereby assign to the above all monies to which I am entitled for counseling/therapy expense relative to the services reported on my insurance claim form. I understand that I am financially responsible to said counselor for charges not covered by this assignment.

X _____ X _____

Insured/Responsible Party Date

New Client Information , Revised July 2004

DJ DIEBOLD, LISAC
DIEBOLD COUNSELING
4850 E. DESERT COVE STE 141
SCOTTSDALE, AZ 85254

INDIVIDUAL TREATMENT PLAN

Client Name: _____ **ID#**_____

Presenting Issue(s): *(please initial)*

___Anger Management
___Dependency
___Financial Stressors
___Medical Problems
___Relational Conflict
___Anxious Mood
___Depressed Mood
___Grief
___Obsessive/Compulsive Behaviors
___Sexual Abuse
___Chemical Abuse/Depend
___Employment Stressors
___Manic Symptoms
___Other (specify)
_____

Manifestations:

_____
_____
_____

Goal:
Client will reduce or eliminate symptoms of above issues
_____ with return to Normal range
_____ by (date) ASAP

Objectives:
Ct. will be
1. 100% honest
2. On time
3. _____
4. _____

Interventions:
Client will
1. Participate in individual counseling
2. Participate in homework as assigned and process with counselor.
3. _____
4. _____

I acknowledge my participation in the development of this treatment plan and I understand and accept the treatment plan.

X _____
Client Signature

DJ Diebold, LISAC
_____

X _____
Date

_____
Date

Reviewed Date
_____ _____
Initial

_____ _____
Initial

DJ DIEBOLD, LISAC
DIEBOLD COUNSELING
~~4850 E. DESERT COVE STE 141~~
SCOTTSDALE, AZ ~~85254~~

INFORMATION ABOUT COUNSELING SERVICES

Counseling involves both time and effort on the part of the therapist and the client. For my part, I will try to be clear about the goals of treatment, what the counseling experience may be like, and approximately how long I expect treatment to take. I welcome questions about any part of the therapeutic process. As we proceed, I will inform you of techniques, procedures, limitations, potential risks, and benefits. For your part, I expect you to keep appointments, to give ample notice in case of cancellation, and to be an active participant in the therapy process. Progress in counseling depends on many factors. Therefore, I cannot guarantee results. Be assured I will give my best effort to help you make progress toward your goals in treatment. I am happy to refer to appropriate alternative services if the need arises.

Typically, I will want to meet with you on a weekly basis. As therapy continues, we may decrease the frequency of sessions. These are general guidelines. Each individual may require less or more frequent contact. Know that you may terminate counseling at any time, with no financial responsibility other than for sessions already attended.

The nature of counseling entails sharing personal information. One of your important rights involves confidentiality. However, I am bound by law to report instances of child abuse; abuse of a vulnerable adult; instances where you might threaten bodily harm to yourself or someone else; commit or threaten to commit a crime; or for medical reasons in a medical emergency. Otherwise, information you share is confidential and will not be shared without your written permission. You need to be aware that I must release information if ordered to by a court of law.

I will make an effort to be available for emergency contact by telephone. If I will be unavailable, I will arrange for a certified or licensed behavioral health professional to cover for me. In this event that professional may be advised of your case. For non-emergency calls, I will contact you as soon as possible. Excessive calls or calls at odd hours are subject to fees comparable with office visits.

I will give you a cellular telephone number to contact me. However, know that any cellular or cordless phones are not secured lines and use of them constitutes your knowledge that the conversation is unsecured.

Fees are established in the first interview. Payment will need to be made at each visit at the beginning of session. Since someone else may have been scheduled should you not show up for an appointment, I do charge you for missed sessions (up to the full fee) unless you cancel 24 hours in advance. If you are a no show or late cancel more than once, you may be withdrawn from DJC service for non-compliance.

I have read the above Information Statement About Counseling Services above, including the sections on confidentiality, risks, benefits and fees. I understand and agree with its provisions, conditions and terms.

X _____ X _____ _____
Client Signature Date SSN

DJ Diebold, LISAC _____
Date

DJ DIEBOLD, LISAC
DIEBOLD COUNSELING
4850 E. DESERT COVE STE 141
SCOTTSDALE, AZ 85254

WHAT TO EXPECT FROM COUNSELING

Many who enter therapy are hoping to find quick relief from some distress they are experiencing. Therapy costs a lot in terms of time, money, and energy and we would like some fast results. Talk to your therapist about your expectations and needs from therapy. The more you express what you want, the better chance you have of receiving it. The majority of individuals who obtain counseling services benefit from the process. Some risks do exist. Some people may experience unhappiness, anger, frustration, guilt, and other uncomfortable feelings. New opportunities and challenges may be an outcome. What may be positive for one individual may be viewed as negative by another, particularly in family relationships. Below is a list of what seems to be true for many people and therapy.

- It takes time to build a trusting relationship with a therapist.
- Go at your own pace so as to not be overwhelmed
- Resistance to change is tempting. If you want to quit right before some real changes occur, remember it is usually about being afraid of change.
- Others may resist your change more than you.
- Be prepared to feel some loss from the changes that occur in therapy.
- It can feel unnatural and unfamiliar to start being more balanced and healthy.
- Therapy can be hard work and can be risky due to personal changes that might produce changes in your various relationships such as work, family, significant others, etc.
- Some therapy is short term (3 – 10 sessions, usually one issue or situation), and some therapy is longer term (more than 10 sessions, complex issues/situations).
- Your therapist is not a perfect human or professional. If mistakes are made, hopefully your therapist will acknowledge this and take responsibility.
- Your therapist must have strong boundaries, refuse dual relationships, maintain firm ethics, and treat you with regard and respect. If any of this is breached, find another therapist.

Signs of a Good Counselor

- *Knowledge* – an academic degree, Masters or Doctorate
- *Training* – ongoing education throughout career
- *Skill* – focused listening without judgment
- *Character* – wisdom, integrity, compassion, humor
- *Certification* – professional associations, certifications
- *Relationships* – ability to develop a healthy, respectful alliance with client

x _____
Client Signature

R J Diebold, LISAC
_____

x _____ _____
Date SSN

_____
Date

DJ DIEBOLD, LISAC
DIEBOLD COUNSELING
4850 E. DESERT COVE STE 141
SCOTTSDALE, AZ 85254

CLIENT RIGHTS

As a client, you have the right:

To receive services:

✓ That respect your privacy and dignity
✓ That are provided in a prompt, courteous and respectful manner
✓ That emphasize your participation in an individualized, written treatment plan
✓ That emphasize ongoing participation in the planning of services as well as in the periodic revision of the treatment plan with a reasonable explanation of all aspects of one's condition and treatment.
✓ That does not require participation in experimentation without your informed, voluntary and written consent.
✓ That is provided in a treatment environment that affords protection from harm, is safe, sanitary and allows for effective treatment with appropriate privacy and freedom from observation by third parties unless consent is obtained from you.
✓ That informs you of any fees to be charged and the methods and schedules of payment.
✓ That in relation to admission, discharge, or treatment, services is given without regard to race, creed, color, gender, sexual preference, age, handicap, national origin or marital status.

To current information about:

✓ HIPAA Notice of Privacy Practices and a copy of said Notice upon request.
✓ Your diagnosis, treatment options that relate to your care, alternatives and accompanying risks, benefits, and costs.
✓ Possible consequences of refusing treatment plan recommendations
✓ Circumstances or conditions under which you may be transferred to another practitioner, program, or facility and the accompanying risks, benefits and cost of such a transfer
✓ Your responsibilities to ensure better treatment outcomes
✓ Your records and having information explained or interpreted as necessary and appropriate
✓ How to access emergency services needed outside of normal business hours.

As a client, you are responsible for:

✓ Being honest and clear about facts, feelings or ideas that relate to your care
✓ Attempting to understand clinical concerns identified and attempting to follow recommendations
✓ Keeping appointments
✓ Reporting changes in your condition to your practitioner

I have read and understood these Client Rights and may have a copy upon my request.

X _____
Client Signature

DJ Diebold, LISAC
_____

X _____
Date

_____
Date

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DIEBOLD COUNSELING
4850 E. DESERT COVE STE 141
SCOTTSDALE, AZ 85254

INFORMED CONSENT FOR TREATMENT

✓ I, _____, DOB _____, ID# —

Give my authorization and consent to receive outpatient diagnostic and treatment services from Counselor, for issues of (check any that apply):

___Anger Management ___Anxious Mood ___Chemical Abuse/Dependence
___Dependency ___Depressed Mood ___Employment Stressors
___Financial Stressors ___Grief ___Manic Symptoms
___Medical Problems ___Social Environment ___Sexual Abuse
___Relational Conflict ___Other (specify) _____

1. Agree to: (*please initial*)
   ✓ freely participate in treatment. I understand that DJ Diebold may determine that additional or specialized evaluation or treatment is clinically necessary and may make appropriate referrals. The number of treatment sessions will be subject to review and modification on an ongoing basis.
   — a mental health evaluation for diagnostic purposes.

2. Have read information regarding the limits of confidentiality of my records. Generally, information from my record cannot be disclosed unless (1) consented to in writing; or (2) allowed by court order; or (3) for medical reasons in a medical emergency; or (4) I commit or threaten to commit a crime. Federal law and State regulations do not protect any information about suspected child abuse or neglect or abuse of a vulnerable adult from being reported to appropriate State or local authorities. (See 42 U.S.C. 290 ee-3 and CFR; A.R.S. 36-509.)

3. Have read Information about Counseling Services and What to Expect from Counseling, particularly risks that may involve change in me and potential changes in relationships due to counseling.

4. Have been given information regarding my rights and responsibilities as an outpatient client including the right to discontinue treatment at any time. (See Client Rights)

5. Have been given information regarding the cost of services. I understand I am responsible for payment/ co-payment of services rendered, and payment is due at the beginning of each session. I am ultimately responsible for all fees incurred regardless of insurance coverage. I agree to pay the deductible required by my insurance plan and the portion of the fees for each session not covered. If these services are not covered by my insurance plan or if I have no insurance coverage, I agree to pay the full fee. I agree to pay any legal fees, court costs, collection fees and late fees connected with collection of payment. I agree that any unpaid balance on my account may be turned over to a collection agency after thirty (30) days of non-payment unless I have made previous payment arrangements with you. I understand an administrative fee will be charged for a late cancellation or no show appointment up to the full session fee.

6. Payment due at the time of service is provided at the following rates:
   $ [redacted]/[redacted] 45/50 minute session 140/120
   $ — co-pay
   $ — deductible (if applicable)

7. *Please initial*:
   — I want you to notify my primary care physician of my participation in counseling.
   PCP Name & Address: _____
   ✓ I do not want you to notify my primary care physician of my participation in counseling.

X _____ X _____
Client signature Date

_____ _____
DJ Diebold, LISAC Date

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SCOTTSDALE, AZ 85254

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement

X I, _____, have received a copy of this office's Notice of Privacy Practices.

X _____
Please Print Name

X _____
Signature

X _____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify)

D. Diebold, LCSW
Witness to client signature

_____
Date

DIEBOLD BEHAVIORAL COUNSELING
www.dieboldbehavioralcounseling.com
8149 North 87th Place Suite 133
Scottsdale, AZ 85258
(480) 650-1020

The following is agreed to in regard to late and missed sessions:

Late sessions constitute arriving 10 minutes or later to a session. Because of the fact that sessions constitute 50 minutes in duration, the aforementioned clinician will determine if this session shall ensue. Should said clinician determine that the session will not ensue, full cost for the session will be due. This is solely and completely up to the determination of the clinician, and will be legally binding. Late sessions that do not ensue will be considered missed sessions.

Missed sessions constitute failure to provide the clinician ***with less than 24 hours*** cancellation or reschedule notice from time of appointment, ***this includes Monday*** appointments. We understand that we all get sick and that unforeseen situations occur. Exceptions can be made at the discretion of the clinician. Missed or late cancel sessions are authorized to be charged on my credit card on file.

Important Note: Momentum is critical in counseling/therapy. Missed and late sessions severely compromise the therapeutic process and hinder growth and healing. We appreciate your understanding in these matters.

Client signature: _____ Date: _____

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Scottsdale, AZ 85258
480-650-1020

INSURANCE WAIVER:

It is hereby agreed that the above provider will provide client with a receipt for dates of service, cost and DSM IV diagnosis. This does not include the insurance company's diagnostic codes. It is agreed that this is their responsibility. Provider ID is my social security number which is not for dissemination. It is the sole responsibility for client to submit the aforementioned for insurance reimbursement. Diebold Behavioral Counseling shall bear no responsibility in this regard.

Client Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Client To keep!

I. YOUR PROTECTED HEALTH INFORMATION:

Your provider is required by law to maintain the privacy of health information that is protected by the federal privacy rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. Your provider is required to abide by the terms of the notice currently in effect. Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for healthcare provided to you, and individually identifies you or reasonably can be used to identify you. Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your provider will take reasonable steps to limit the use of or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose.

A. Treatment, payment, and health care operations

This section describes how your provider may use and disclose your protected health information for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment

Your provider may use and disclose your protected health information for treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers.

Your provider may share and discuss your medical information with an outside practitioner to whom your provider has referred you for care.

Your provider may share and discuss your medical information with an outside practitioner with whom your provider is consulting regarding you.

Your provider may share and discuss your medical information with a hospital or other health care facility where you are being admitted or treated.

Your provider may contact you to provide appointment reminders.

2. Payment

Your provider may use and disclose your protected health information for payment purposes. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, from your health insurer. Some examples of payment uses and disclosures include:

Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.

Submission of a claim form to your health insurer.

Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.

Mailing you bills in envelopes with your provider's practice name and return address.

Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.

Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.

Allowing your health insurer access to your medical record for a medical necessity or quality review audit.

Providing information to a collection agency or attorney for purposes of securing payment of a delinquent account.

Disclosing information in a legal action for purposes of securing payment of a delinquent account.

3. Health care operations

Your provider may use and disclose your protected health information for health care operation purposes as well as certain health care operation purposes health plans. Some examples of health care operation purposes include:

Quality assessment and improvement activities.

Health care fraud and abuse detection and compliance programs.

Conducting other medical review, legal services, and auditing functions.

Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.

B. Uses and disclosures for other purposes

1. Required by law

Your provider may use and disclose protected health information when required by federal, state, or local law. For example, your provider may disclose protected health information to comply with mandatory child abuse, elder abuse, domestic violence, driving impairments, medical reasons in a medical emergency, you commit or threaten to commit a crime or if you represent a clear risk of harm to yourself or others, public health activities (communicable disease, injuries, vital events such as a death), disaster relief efforts.

2. Judicial and administrative proceedings

Your provider may use and disclose protected health information disclosures in judicial and administrative proceedings in response to a court order or subpoena, discovery request or other lawful process. For example, your provider may comply with a court order to testify in a case at which your mental health or substance use condition is at issue.

III. PATIENT PRIVACY RIGHTS

A. Further restriction on use or disclosure

You have a right to request that your provider further restrict use and disclosure of your protected health information (i) to carry out treatment, payment or health care operations, (ii) to someone who is involved in your care or the payment for your care, or (iii) for notification purposes. Your provider is not required to agree to a request for a further restriction. To request a further restriction, you must submit a written request to your doctor. The request must detail (a) what information you want restricted; (b) how you want the information restricted; and (c) to whom you want the restriction to apply.

B. Confidential communication

You have a right to request your provider communicate your protected health information to you by a certain means or at a certain location. Your provider is not required to agree to requests for confidential communications that are unreasonable. To make a request for confidential communications, you must submit a written request to your provider. The request must tell your provider how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Accounting of disclosures

You have a right to obtain, upon request, an "accounting" of certain disclosures of your protected health information by us. This right is limited to disclosures within six years of the request and other limitations. Also in limited circumstance we may charge you for providing the accounting. To request an accounting, you must submit a written request to your provider.

D. Inspection and copying

You have a right to inspect and obtain a copy of your protected health information that is maintained in a designated records set. This right is subject to limitations (for example, if access is likely to endanger the life, well-being or safety of the individual or another person or if the record makes reference to another individual). Your provider may impose a charge for the labor and supplies involved in providing copies. To exercise your right of access, you must submit a detailed, written request. The request must (a) describe the health information to which access is requested, (b) state how you want to access the information. Only paper copy will be provided.

E. Right to amendment

You have a right to request your provider amend protected health information that is maintained about you in a designated records set if the information is incorrect or incomplete. This right is subject to limitations. To request an amendment, you must submit a written request to your provider. The request must specify each change that you want and provide a reason to support each requested change.

F. Paper copy of privacy notice

You have a right to receive, upon request, a paper copy of our Notice of Privacy Practices. To obtain a paper copy, please notify your therapist.

IV. COMPLAINTS

If you believe that your provider has violated your privacy rights and are unable to resolve this with your provider to your satisfaction, you may submit a complaint to the United States Department of Health and Human Services, Office of Civil Rights – HIPAA. Your provider will not retaliate against you for filing a complaint.

V. LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.

The counselor reserves the right to change the terms of this Notice and to make the new notice provisions effective for all protected health/mental health information. Individuals may obtain a copy of the revised Notice upon request.

INITIAL QUESTIONNAIRE

PLEASE PRINT #101

Date_____

Your Initials:____ ____ ____ Age:_____ M____ F____

Do you attend a 12-Step Program?

___Currently Attending ___Attended in Past, but not currently ___Never Attended

How long have you been sober from ALCOHOL?

____Never Drank ____Less than 7 days ____ 7 - 21 days ____22 - 30 days
____31 - 60 days ____61 - 364 days ____1 - 3 years ____More than 3 years

Do you still have CRAVINGS for alcohol? ____Yes ____No

How long have you been sober from DRUGS?

____Never Used Drugs ____Less than 7 days ____ 7 - 21 days ____22 - 30 days
____31 - 60 days ____61 - 364 days ____1 - 3 years ____More than 3 years

Do you still have CRAVINGS for drugs? ____Yes ____No

Please rate CRAVINGS from 1 to 5
1 = not at all 2 = occasionally 3 = can do without it 4 = must have it daily 5 = constant cravings

How strong are your addictive CRAVINGS for:
____Alcohol ____Caffeine ____Chocolate ____Cocaine
____Crack ____Crystal Meth ____Heroin ____Marijuana
____Sugar ____Tobacco ____Other

Please rate USAGE from 1 to 5
1 = not at all 2 = occasionally 3 = can do without it 4 = must have it daily 5 = constant cravings

How often are you USING: Recent Past
____Alcohol ____Caffeine ____Chocolate ____Cocaine
____Crack ____Crystal Meth ____Heroin ____Marijuana
____Sugar ____Tobacco ____Other

I AGREE TO FOLLOW-UP WITH A FINAL QUESTIONNAIRE WITHIN 45 DAYS ___ ___ ___