## D.J. DIEBOLD, CAC, LISAC DIEBOLD BEHAVIORAL COUNSELING

9375 E. Shea Blvd. Suite 278 Scottsdale, AZ 85260

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

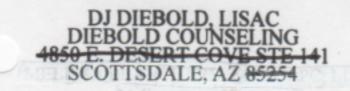
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## DJ DIEBOLD, LISAC DIEBOLD COUNSELING 4850 E. DESERT COVE STE 141 SCOTTSDALE, AZ 85254

## INDIVIDUAL TREATMENT PLAN

√Client Name:	ID#	
DependencyDependencyDependencyDependency Gri	pressed Mood ief sessive/Compulsive Behav	Chemical Abuse/Depend Employment Stressors Manic Symptoms viors Other (specify)
√Manifestations:		
✓Goal: Client will reduce or eliminate sympte————with	return to Normal range	46.5
Objectives: Ct. will be 1. /oo% howest 2. DN Time		
4		
Interventions: Client will 1. Participate in individual counseling 2. Participate in homework as assigned 3. 4.	ed and process with couns	elor.
I acknowledge my participation in the the treatment plan.	development of this treatr	nent plan and I understand and accept
Client Signature  J H Lbold, LISAE	Date	Reviewed Date  Initial
- 1 40010, 219/12	Date	- }

Individual Treatment Plan Revised July 2004



## 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.

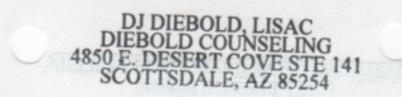
Typically, I will want to meet with you on a weekly basis. As therapy continues, we may decrease the frequency of sessions. These are general guidelines. Each individual may require less or more frequent contact. Know that you may terminate counseling at any time, with no financial responsibility other 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. Payr session. Since someone else may have been sol charge you for missed sessions (up to the full fe show or late cancel more than once, you may be compliance.	heduled should you not be unless you cancel 24	show up for an apport	intment, I do
I have read the above Information Statement All confidentiality, risks, benefits and fees. I under	oout Counseling Service stand and agree with its	es above, including to provisions, conditions	he sections on ons and terms.
	X		_
Client Signature	Date	SSN	
OT Sirbold, LISAC	Date		



## WHAT TO EXPECT FROM COUNSELING

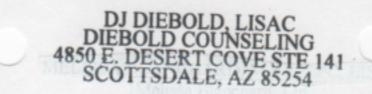
Many who enter therapy are hoping to find quick relief from some distress they are experiencing. Therapy costs a lot in terms of time, money, and energy and we would like some fast results. Talk to your therapist about your expectations and needs from therapy. The more you express what you want, the 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  Libert 4, Usk	Date	SSN
N JUDOLE, CISAC		
Masussa, Blanchard, M. Ed., LPC, LISAO	Date	



## **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	X	
Client Signature	Date	
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Wiehs at Blauchard, Williad, T.P.C., LISAC	Date	

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

## INFORMED CONSENT FOR TREATMENT

/	I, _		, DOB	, ID#
	Cou	inselor, for issues of check any	y that apply):	agnostic and treatment services from
	-	Anger Management Anx		Chemical Abuse/Dependence
		TO! ! ! #	ressed Mood	Employment Stressors
		Financial Stressors Grie Medical Problems Soci		Manic Symptoms
		Relational Conflict	ial EnvironmentOther (specify)	Sexual Abuse
	1.	Agree to: (please initial)		
		additional or spec	cialized evaluation or tre	and that IT Diebold may determine that eatment is clinically necessary and may make appropriations will be subject to review and modification on an
		a mental health e	valuation for diagnostic	purposes.
	2.	medical reasons in a medic State regulations do not pro	cal emergency; or (4) I ontention all of the contents of the c	fidentiality of my records. Generally, information from d to in writing; or (2) allowed by court order; or (3) for commit or threaten to commit a crime. Federal law and yout suspected child abuse or neglect or abuse of a e State or local authorities. (See 42 U.S.C. 290 ee-3 and
	3.	Have read <u>Information abo</u> that may involve change in	out Counseling Services in me and potential change	and What to Expect from Counseling, particularly risks es in relationships due to counseling.
	4.	Have been given information right to discontinue treatment	on regarding my rights ent at any time. (See Cl	and responsibilities as an outpatient client including the ient Rights)
	5.	by my insurance plan and to covered by my insurance plan and to covered by my insurance plan and to pay any legal fees, court couthat any unpaid balance on non-payment unless I have	dered, and payment is durred regardless of insur- the portion of the fees folian or if I have no insur- lests, collection fees and my account may be tun- made previous paymen	services. I understand I am responsible for payment/ ue at the beginning of each session. I am ultimately ance coverage. I agree to pay the deductible required r each session not covered. If these services are not ance coverage, I agree to pay the full fee. I agree to late fees connected with collection of payment. I agree ned over to a collection agency after thirty (30) days of arrangements with you. I understand an ation or no show appointment up to the full session fee
6	5.	Payment due at the time of \$ 45/50 \$ co-	service is provided at the minute session / 4 o / pay ductible (if applicable)	e following rates:
7		PCP Name & Add	TREE.	of my participation in counseling.
/		I do not want you to no	bury my primary care ph	ysician of my participation in counseling.
-	liant	teianatura		X
-	0	t signature		Date
	1	Dibord, 45	se	Date
I	nform	med Consent for Treatment		Revised July 2004

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

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign	This Acknowledgement
T	
I, this office's Notice of Privacy Practices.	, have received a copy o
Please Print Name	
Signature	
Date	
For Office U	Jse Only
We attempted to obtain written acknowledgement could not be obtained.	ent of receipt of our Notice of Privacy tained because:
<ul> <li>Individual refused to sign</li> <li>Communication barriers prohibited obta</li> <li>An emergency situation prevented us from Other (please specify)</li> </ul>	aining the acknowledgement om obtaining acknowledgement
District yese	

## DIEBOLD BEHAVIORAL COUNSELING

8149 North 87<sup>th</sup> 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:	

## DIEBOLD BEHAVIORAL COUNSELING

D.J. Diebold, CAC, LISAC 8149 North 87<sup>th</sup> Place Ste 133 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:
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## 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

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

Your Initials:	Age:	M	F	
Do you attend a 12-St	ep Program?			
Currently Attending	ngAttended in Past, l	out not currently	Never Attend	ed
How long have you b	een sober from ALCOHOI	?		
Never Drank31 - 60 days	Less than 7 days 61 - 364 days	7 - 21 days 1 - 3 years	22 - 30 da More than	ys a 3 years
Do you still have CR	AVINGS for alcohol?	YesNo		
How long have you b	een sober from DRUGS?			
Never Used Dru	Less than 7 days	7 - 21 da	22 - 30 More th	days nan 3 years
	AVINGS for drugs?			
Please rate CRAVIN 1 = not at all 2 = c cravings			nust have it daily	5 = const
1 = not at all 2 = c cravings	addictive CRAVINGS for CaffeineC Crystal MethH	without it $4 = r$	nust have it daily  Cocaine  Marijuana	5 = const
1 = not at all 2 = o cravings  How strong are yourAlcoholCrackSugar  Please rate USAGE 1 = not at all 2 = o cravings	addictive CRAVINGS for CaffeineC Crystal MethH TobaccoO  from 1 to 5	without it $4 = r$ hocolate feroin ther  without it $4 = r$	Cocaine	5 = const