

Diebold Behavioral Counseling

D.J. Diebold, CAC, LISAC

New Client Information

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____

Phone: _____ Email: _____

May I contact you by phone/text message/voice mail/email? ____ Yes ____ No

Employer name and phone number: _____

Who referred you? _____ May I send a Referral Thank You to them? ____ Yes ____ No

Emergency Contact

Name: _____ Relation to client: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

May I contact them by phone/text message/voice mail/email? ____ Yes ____ No

Client Signature

Date

Initial Questionnaire

Name Age Gender Date

Do you attend a 12-step program? ☐ Currently attending ☐ Attended in the past, but not currently ☐ Never Attended

How long have you been sober from **alcohol**?

☐ Never Drank ☐ 22-30 days ☐ 1-3 years
☐ Less than 7 days ☐ 31-60 days ☐ More than 3 years
☐ 7-21 days ☐ 61-364 days

Do you still have **cravings** for alcohol? ☐ Yes ☐ No

How long have you been sober from **drugs**?

☐ Never Used Drugs ☐ 22-30 days ☐ 1-3 years
☐ Less than 7 days ☐ 31-60 days ☐ More than 3 years
☐ 7-21 days ☐ 61-364 days

Do you still have **cravings** for drugs? ☐ Yes ☐ No

Please rate your **cravings** from 1 to 5:

1: Not at all, 2: Occasionally, 3: Can do without, 4: Must have it daily, 5: Constant

☐ Alcohol ☐ Caffeine ☐ Chocolate ☐ Marijuana
☐ Crack ☐ Crystal Meth ☐ Heroin ☐ Other
☐ Sugar ☐ Tobacco ☐ Cocaine

How often have you been recently **using**: (daily, weekly, monthly, never)

☐ Alcohol ☐ Caffeine ☐ Chocolate ☐ Marijuana
☐ Crack ☐ Crystal Meth ☐ Heroin ☐ Other
☐ Sugar ☐ Tobacco ☐ Cocaine

By submitting this form, I agree to follow up with a final questionnaire within 45 days.

Individual Treatment Plan

Name: _____

Presenting Issue(s)

- | | | |
|--|---|--|
| ☐ Anger Management | ☐ Anxious Mood | ☐ Chemical Abuse/Dependence |
| ☐ Dependency | ☐ Depressed Mood | ☐ Employment Stressors |
| ☐ Financial Stressors | ☐ Grief | ☐ Manic Symptoms |
| ☐ Medical Problems | ☐ Obsessive/Compulsive | ☐ Sexual Abuse |
| ☐ Relational Conflict | ☐ Other: _____ | |

Manifestations:

Goals: Client will reduce or eliminate symptoms of the above issues with a return to the normal range as soon as possible.

Objectives: Client 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.

Client Signature

Date

Provider

Date

Information About Counseling Services

Counseling involves both time and effort on the part of the therapist and 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. Therefore, 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 try 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 must be made at each visit at the beginning of session. Should you not show up for an appointment, you will be charged for the missed session (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 our service for non-compliance.

I have read the above information statement about counseling services, including the sections on confidentiality, risks, benefit, and fees. I understand and agree with its provisions, conditions, and terms.

Client Signature

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 to see 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 in therapy.

- It takes time to build a trusting relationship with the therapist.
- Go at your own pace so as not to 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

Client Signature

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 do not require participation in experimentation without your informed, voluntary, and written consent.
- That are 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 inform you of any fees to be charged and the methods and schedules of payment.
- That in relation to admission, discharge, or treatment, services are given without regard to race, creed, color, gender, sexual preference, age, handicap, national origin, or marital status.

And 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 costs 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 of it upon my request.

Client Signature

Date

Informed Consent for Treatment

Name: _____ Date of Birth: _____

I give my authorization and consent to receive outpatient diagnostic and treatment services from a counselor for issues of:

Anger Management	Anxious Mood	Chemical Abuse/Dependency
Dependency	Depressed Mood	Employment Stressors
Financial Stressors	Grief	Manic Symptoms
Medical Problems	Social Environment	Sexual Abuse
Relational Conflict	Other	

1. I agree to freely participate in treatment. I understand that D.J. 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.
2. I 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. I 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. I 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. I have been given information regarding the cost of services. I understand that 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 a no show appointment up to the full session fee.
6. Payment is due at the time of service at the following rate: \$____ for a ____-minute session.
7. I understand that you will not notify my primary care physician of my participation in counseling.

Client Signature

Date

D.J. Diebold, LISAC

Date

Acknowledgment of Receipt of Notice of Privacy Practices

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

Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other: _____

Witness to Client Signature

Date

Late or Missed Sessions

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

Late sessions constitute arriving 10 minutes or later to a session. Because sessions constitute 50 minutes in duration, the clinician, D.J. Diebold, will determine if the session shall ensue. Should the clinician determine that the session will not ensue, full cost of 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 rescheduling notice from the time of the 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-canceled sessions may be charged to 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 Name

Client Signature

Date

Insurance Waiver

It is hereby agreed that the Provider, D.J. Diebold, will provide the 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 of the client to submit the aforementioned for insurance reimbursement. Diebold Behavioral Counseling shall bear no responsibility in this regard.

Client Name

Client Signature

Date

Notice of Privacy Practices (HIPAA)

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.**

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 healthcare 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 healthcare operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and healthcare operations purposes will be listed.

i. Treatment

Your Provider may use and disclose your protected health information for treatment purposes as well as the treatment purposes of other healthcare 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.

ii. 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 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 providers 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 records 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.

iii. Health care operations

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

quality assessment and improvement activities

healthcare 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 federal privacy rule and resolution of patient grievances

Diebold Behavioral Counseling

b. Uses and disclosures for other purposes

i. 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 and 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.

ii. Judicial and administrative proceedings

Your Provider may use and disclose protected health information in judicial and administrative proceedings in response to a court order or subpoena, discovery request, or other lawful purposes. 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 healthcare operations, (ii) to someone who was 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 further restriction. To request a further restriction, you must submit a written request to your Provider. The request must detail (a) what information you want restricted; (b) how you want the information restricted; (c) to whom you want the restriction to apply.

b. Confidential communications

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 circumstances, 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 record 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 for which access is requested, (b) state how you want to access the information. Only a 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 record set if the information is inaccurate or incomplete. The 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 Provider.

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 make the new Notice provisions effective for all protected health/mental health information. Individuals may obtain a copy of the revised Notice upon request.