Claudia Diez, PhD, ABPP | 212.744.8073

Registration and Informed Consent for Services
NYS Lic. 017761

Date:	
Referred by:	

Name *(First MI Last):*		☐ **M**	☐ **F**	**DOB:**	**Age:**
Address: *(Street, Apt#)*		**City, State, & ZIP:**			
Main Phone		May we leave a message?		☐ Yes	☐ No
Other Phone		**E-mail:**			
Form of Payment (include rate)	☐ **Direct Pay** **Fee per hr/visit: $** _____	**OON PPO Plan ID for reimbursement**			
Emergency Contact					
Highest Education		**Occupation**			

Marital status	☐ **Single**	☐ **Partnered**	☐ **Married**	☐ **Separated**	☐ **Divorced**	☐ **Widowed**
Children	☐ **No**	☐ **Yes**	**Age of Children:**		

Service you are seeking (Please choose only ONE)	☐ Consultation	☐ Evaluation Only
	☐ Individual Therapy	☐ Evaluation Only for (second opinion on diagnosis, etc.)
	☐ Couples Therapy	☐ _____

Reason(s) for seeking services	☐ Abuse	☐ Conflict with Partner	☐ Eating Disorder (height _____ weight _____)	☐ Stress
	☐ Anxiety/Panic	☐ Conflict at Work	☐ Grieving / Bereavement	☐ Trauma
	☐ Attention Problems	☐ Depression/ Mood	☐ Relationship Issues	☐ Other_____

How long have you experienced the problems checked off above?		
Is this your first time requesting treatment by a psychiatrist, psychologist, or therapist?	☐ Yes	☐ No
If no, when was the last time you were seen and who were you seen by?		
Have you had any previous psychiatric hospitalizations?	☐ Yes	☐ No
If yes, when and how many?		
Have you ever attempted suicide? If yes, when?	☐ Yes	☐ No
**If you currently experience suicidal or homicidal thoughts and plan to act on them, please dial 911 or go to your nearest emergency room **		
Did you ever caused yourself intentional injuries (i.e., cutting, burning)?	☐ Yes	☐ No

Do you drink alcohol (beer/wine/liquor)? ☐ Yes ☐ No **How often?:** Rarely | Occasionally | Frequently | Consistently

Use recreational drugs: marijuana | cocaine | heroin | other ☐ Yes ☐ No **How often?:** Rarely | Occasionally | Frequently | Consistently

Are you currently involved in any legal proceedings (lawsuits, divorce, child custody, etc.)?	☐ Yes	☐ No
Do you have any pending disability claims OR do you plan to file a disability claim in the near future?	☐ Yes	☐ No

Any medical problems? If yes, please list the most severe:

Any known mental health diagnoses?
If so, year when it was diagnosed:

Any Current Medication	

Are you having any difficulty sleeping (falling asleep, staying asleep, and/or waking frequently)?	☐ Yes	☐ No
Are you having any difficulty with your appetite (loss of or increase of)?	☐ Yes	☐ No
Are you having difficulty attending work or with your day-to-day activities (ex: household chores)?	☐ Yes	☐ No

Reason for this consultation:

Last Name, First Initial	

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CANCELLATION POLICY
Once a regular appointment time is reserved for you on mutual agreement, you are responsible for attending those appointments regularly. **Charges apply for missed or cancelled sessions.** Cancellations will be free of charge if made three business days (72 hrs) in advance. Missed or cancelled appointment fees are not covered by insurances; they are your solely responsibility. The first missed appointment or cancellation carries **a $100 fee**. All other cancelled appointments are subject to a full encounter fee, except if/when agreed upon otherwise. To avoid cancellation fees please inform us of your absence 72 hours in advance and/or inquire about scheduling a make-up appointment within 5 business days. If you cancel or miss an appointment and do not request a make-up session, charges will be billed automatically. **~**Frequent cancellations or missed appointments may result in losing your reserved time slot and/or discontinuation of services.

PAYMENT FOR SERVICES
• Dr. Diez is an Out of Network provider for all insurances. Payment of the agreed upon fee is due at time of service (per visit) unless otherwise specified. Payments can be submitted via Zelle to info@drclaudiadiez.com, or via Venmo. Inquire about other forms of payment if you cannot access these online services.
• Notify Dr. Diez as soon as possible if any problems arise during the course of therapy regarding your ability to make timely payments, or if there are changes of insurance coverage. If your insurance plan, for whatever reason, makes the decision of withholding payment for the services rendered, you are responsible for making direct payments for those services. Payment arrangements will be made with Dr. Diez should this situation arise.
• Because Dr. Diez is an *Out of Network* provider (not in your health plan's panel), you are responsible for the direct payment of services at time of service rendered, unless otherwise arranged. You are also responsible for collecting reimbursement from your insurance plan, and to contact your insurance when/if claims remain open for more than 40 days. Reimbursements by your insurance are not warranted. Please discuss finances as soon as possible with Dr. Diez to prevent billing conflicts or disruption of payment or services.
• Remote sessions are conducted via Doxy or FaceTime for clients in the United States, or via WhatsApp with international clients.
• Preparation of forms or documents (letters to employer, schools, insurance claim agencies, etc.), document reviews, and communications with other parties (i.e. doctors, family members), either requested by the client or necessary to perform adequate services, are subject to additional fees comparative to the fee established per session and prorated based on time spent on those services.

CONFIDENTIALITY AND ITS LIMITS
Meetings between a client and a clinician are confidential and legally privileged. Dr. Diez will not release information discussed to anyone without a client's written permission, except the minimally necessary for insurance billing purposes (diagnoses code, date and type of service). Based on current HIPPA laws, in the following important situations clinicians are legally and ethically required to go outside the context of the therapeutic relationship and release necessary information about the client in order to preserve his/her safety or that of another:
(1) If there is an emergency situation in which the clinician believes that the client may be a danger to her/himself or that s/he is gravely disabled;
(2) If the client communicates a serious threat of violence against someone in particular to the clinician;
(3) If the clinician has reasonable suspicion that a child or elder/dependent adult is being abused; or
(4) If the client's records are subpoenaed as evidence during a legal proceeding.
If any such situation arises, Dr. Diez will attempt to fully discuss it with the client before taking any action and will limit the disclosure to what is strictly necessary given the circumstances.
Disclosure of confidential information may be required by the client's insurance carrier in order to process a claim. In this circumstance, only the minimum amount of information will be communicated to the carrier.
In case of neglect or refusal to pay a balance, basic information may be provided to a collection agency or small claims court in order to secure payment.

EMERGENCIES
If you experience an emergency please call 911 or go to the nearest emergency room.

If you have questions or concerns about the above terms please discuss them with Dr. Diez before signing this form or initiating treatment

CONSENT FOR SERVICES

I hereby authorize Dr. Claudia Diez to evaluate me and /or treat me, and to release, if I so request, to insurance carriers financially liable for my care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also acknowledge awareness of cancellation fees, confidentiality and privacy restrictions as per HIPPA laws described above.

I _____, I have been informed and understand the above terms.

Client's electronic signature _____ Date _____

Your feedback is welcome, any time. Thank you, Dr. Diez