

Claudia Diez, PhD, ABPP | 212.744.8073

Registration and Informed Consent for Services

NYS Lic. 017761 | CT Lic. 4486

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:

Partnership 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

Coaching/Skills Training

Couples Counseling

Other: _____

Reason(s) for services

Coaching Skills

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 coach?

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: THC | cocaine | psychedelic | other

Yes No

How often?: Rarely | Occasionally | Frequently | Consistently

Are you currently involved in any related legal proceedings (divorce, child custody, assault, etc.)?

Yes

No

Note: Dr Diez does not provide documentation to support legal claims

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, 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:

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Last Name, First Initial

BOOKING APPOINTMENTS: In order to reserve your initial booking, please submit \$50 via Zelle to info@drclaudiadiez.com, or via Venmo to [@Claudia-Diez](https://www.venmo.com/@Claudia-Diez)

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 **50% of arranged fee.** All other late 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

- Payments are direct, via Zelle, Venmo or cash. Payment of the agreed upon fee is due at time of service (per visit) unless otherwise specified. Inquire about other forms of payment if you cannot access online payments. Alternative payment arrangements may be arranged if an existing client provides information about specific financial hardship.
- For clinical services (psychotherapy or couples, family therapy), Dr. Diez will issue a bill to process reimbursements. Notify Dr. Diez as soon as possible if any problems arise during the course of the sessions regarding your ability to make timely payments, or if there are changes of insurance coverage. If you are covered by a health insurance plan, and the plan withholding payment for the services rendered, you are responsible for making direct payments for those services.
- Because Dr. Diez is an *Out of Network* provider (not in health plans directories), 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 Zoom or FaceTime for clients in the United States, or other online services 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 clinical circumstances the providers 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, or coach 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 always welcome; please talk to Dr. Diez or email us at info@drclaudiadiez.com with comments and suggestions**