Diane Prince Goula LCSW — Board Certified Diplomate in Clinical Social Work

14362 N. Frank Lloyd Wright Blvd. #2151, Scottsdale, AZ 85260
e-mail: Diane@DianeGoula.com, www.DianeGoula.com
O: (480)991-0296, Fax: (480)436-6666

NEW CLIENT INFORMATION- ADULT

Patient's Name:_____ **Sex: M/F DOB:**_____ **Age:**___ **SSN:**_____

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

Home Phone:_____ **Work Phone:**_____ **Mobile:**_____ **E-Mail:**_____

May I text appointment reminders to you? If so, please list your mobile carrier:_____ **and/or by e-mail? Yes No**
Authorization to leave messages with family members or on home answering machine? Yes No On work voicemail? Yes No Initials_____

Name of Emergency Contact:_____ **Phone #:**_____ **Relationship:**_____

****

Spouse or Significant Other also seen in the Same appointment: _____

Sex: M/F DOB:_____ **Age:**____ **SSN:**_____

Home Phone:_____ **Work Phone:**_____ **Mobile:**_____ **E-Mail:**_____

May I text appointment reminders to you? If so, please list your mobile carrier:_____ **and/or by e-mail? Yes No**
Authorization to leave messages with family members or on home answering machine? Yes No On work voicemail? Yes No Initials_____

****

Referred by: Insurance Work EAP Friend Other:_____ **Auth. #:**_____

#of sessions authorized _____ **Co-pay amount** _____ **Has your deductible been met? Yes No N/A**

Name of Primary Insured:_____ **DOB:**_____ **SSN:**_____

Name of Insurance Plan:_____ **ID #:**_____ **Group/ Account #:**_____

Number to check benefits/ eligibility on back of card_____ **Name of Employer:**_____

****

Name of Secondary Insured:_____ **DOB:**_____ **SSN:**_____

Name of Insurance Plan:_____ **ID #:**_____ **Group #:**_____

Number to check benefits/ eligibility on back of card_____ **Name of Employer:**_____

****

REPORT OF ABUSE: I understand that state laws require that Diane Goula report all cases of physical or sexual abuse or neglect of minors or the elderly and, in all cases in which the patient presents as a danger to themselves or others.

Signature:_____ **Date:**_____

Please list any medical conditions:_____

What medications are you currently taking? N/A

NAME	DOSAGE	WHEN TAKEN	WHO IS PRESCRIBING?

Alcohol usage: ___ABSTINENCE ___SOCIAL(1 to 2 drinks w/ others) ___HEAVY (3+)

Do you or others close to you have concerns about your drinking or use of prescription/ illegal drugs? __YES __NO

If you answered yes, please explain:_____

_____

Have you ever received treatment for alcohol abuse or substance abuse? YES____NO____ If you answered yes, list date(s) and who you saw for treatment?_____

Does you smoke? YES____NO____ If you answered yes, how many cigarettes per day?_____

How much caffeine (coffee, tea, sodas) do you drink per day?_____

****

Previous counseling: List date(s) and name of provider(s) and hospitalizations:_____

_____

Why are you seeking counseling at this time?_____

If counseling were to be helpful what changes would you like to see in yourself and/or others? (This will become your treatment plan.)

1. _____
2. _____
3. _____
4. _____

Signature_____ Date_____

Therapist signature _____ Date_____

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FINANCIAL AGREEMENT

AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS: I hereby authorize insurance payments to be made directly to Diane Goula. I authorize Diane Goula to release necessary information to my insurance company to secure the payment of benefits.

I understand that I, not my insurance company, am financially responsible for any charges which become ineligible or are denied by my insurance carrier. If, for some reason, the information regarding my insurance coverage changes or my coverage is terminated, I will immediately notify Diane Gouda.

If I fail to pay an outstanding balance within 60 days, Diane Goula will refer this to a collection agency and will charge me for the cost of collection in addition to my balance.

Signature:_____Date_____

CANCELLATION POLICY: I understand that by making an appointment I am contracting for Diane Goula's time. Therefore, prior notice, by 5:00 pm the day preceding my appointment, is required for all cancellations and that I may cancel my appointment by notifying the answering service, Diane@DianeGoula.com or Diane Goula's voicemail, 480-991-0296, available 24 hours per day. I understand that insurance will not pay for missed appointments and that I will be held responsible for payment of missed appointments or late cancellations of a non-emergency nature as missing my appointment doesn't allow the time to schedule another client. This charge will be $60.00 for the first missed appointment and $100.00 thereafter. I understand that if I Fail to Show or Late Cancel my first appointment, I will be required to put a credit/ debit card on hold before I can schedule another appointment.

Signature:_____Date_____

I authorize Diane Goula, L.C.S.W. to keep my signature on file and to charge my credit/debit account for:

- **Recurring charges/ co-pays (on-going treatments) of $_____every session from_____ (onset of therapy to _____(end of therapy).**
  (fee) (date) (date)
- **Balances of charges not paid to me or from insurance within 90 days and not to exceed $_____ for:**
  This visit only_____ All visits_____
- **No Show/ Non-emergent late cancellations (not made prior to 5:00 pm on the day preceding scheduled appointment).**

I understand that I may revoke this agreement at any time by providing a request in writing.

Client's Name_____ Cardholder's Name_____

Cardholder's address_____

City_____State_____Zip_____

_____Visa _____Mastercard (American Express or Discover not accepted)

Account Number_____Expiration date_____CCV Code:_____

Signature_____ Date_____

I agree to only charge for services rendered, failure to show for appointment or for non-emergent cancellations if appointment is not cancelled by 5:00 pm on the day preceding your scheduled appointment.

Diane Goula, L.C.S.W._____Date_____

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RELEASE OF INFORMATION

To: (Name of your Primary Care Physician, treating psychiatrist or behavioral health clinician)

Name/Agency____
Address____
City, State, Zip____
Telephone:______________________ Fax:______________________

CLIENT:____ DOB______________

PERMISSION TO RECEIVE, RELEASE, OR EXCHANGE INFORMATION

The agency and/or individual above is authorized to:

- ☐ receive the type(s) of information indicated below from Diane Goula, LCSW.
- ☐ release and transmit the type(s) of information indicated below to Diane Goula, LCSW.
- ☐ exchange and transmit the type(s) of information indicated below with Diane Goula, LCSW.

It is understood that this information may be shared through verbal and/or written means for treatment planning.

☐ Medical History	☐ Psychosocial History	☐ Teacher Observations
☐ Hospital Records	☐ Psychological Evaluation	☐ Educational Tests
☐ Psychiatric Exam	☐ Counseling Progress Notes	☐ School Records
☐ ______________	☐ ______________	☐ ______________

It is understood that records are protected under federal confidentiality regulations and cannot be released without the permission of the client unless otherwise provided for in the regulations.

By signing this consent form, I voluntarily waive the confidentiality of the above noted information which would otherwise be protected by law. Unless revoked earlier, it is mutually understood that this consent expires in ninety days or on the day of my discharge from treatment with Diane Goula, LCSW (whichever is later).

____Date______________
Signature of Client

____
Signature of Parent or Guardian (if client is a minor)

✸✸

I decline the sharing of counseling information with my Primary Care Physician.

____
Signature of Client Date

(This release of information is designed to satisfy federal confidentiality guidelines)
A photo copy of this release is valid.

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NOTICE OF PRIVACY POLICIES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as **Protected Health Information** (**"PHI"**). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and professional codes of ethics. It also describes your rights regarding how you may gain access and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice. I reserve the right to change the terms of this Notice at any time. Any new Notice will be effective for all PHI that I maintain at that time. I will provide you with a copy of any revised Notice of Privacy Practices at your request.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care and for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment provided to you only with your authorization. This may include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review practices. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

Your PHI will also be used by my scheduler to call/leave appointment reminders UNLESS YOU REQUEST IN WRITING THAT THIS NOT BE DONE. You will be asked for a telephone number where we can reach you or leave a reminder message.

I may call you by name in the waiting room when I am ready to see you for your appointment.

When communicating by telephone, I will provide information to you only, regarding your care, or to the parents/legal guardians of minors. Exceptions to this are noted elsewhere in this Notice.

Required by Law: Under the law I must make disclosure of your PHI to you upon your request. In addition I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT

I may use your PHI without your consent in the following situations: a) when disclosure is required by federal. state, or local law; b) when abuse or neglect is suspected: c) for judicial and administrative proceedings: d) in the event of a patient's death; e) in emergency situations; f) in situations where a family member is involved in your care; g) if health oversight is suspected: h) if requested by law enforcement agencies or national security agencies; j) for Workman's Compensation purposes; k) if it is my duty to warn that you are a danger to yourself, others, or the property of others; l) mandatory government audits or investigations; m) court orders; n)for research purposes.

Verbal Permission: I may use or disclose your information to family members who are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me. You may incur reasonable charges for these requests.

a) You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right will be restricted only in those situations where there is compelling evidence that access would cause you serious harm to you. Psychotherapy notes have special protection under HIPAA. Psychotherapy notes are intended for the my sole use. The right to view or get copies of your PHI does **not** include access to psychotherapy notes.
b)You have the right to ask me to amend any information in your PHI that you feel is incorrect or incomplete, although I am not required to agree to the amendment.
c) You have the right to request an accounting of certain disclosures that I make of your PHI. The list will not include disclosures to which you have already consented or disclosure you made prior to April 15, 2003. I may require a reasonable fee if you request more than one accounting per 12-month period.
d) You have the right to request a limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. I am not required to agree to your request.
e) You have the right to request that your PHI be sent to you at an alternate address or by an alternate method, provided this can be done without my undue inconvenience.
f) You have the right to keep a copy of this Notice.

COMPLAINTS

If you wish to submit a comment or complaint about my privacy practices or you feel that your privacy rights have been violated, please tell me about it in person. If this isn't resolved to your satisfaction, please submit a written complaint to me at my office address. I will **not** penalize or retaliate against you for filing a complaint.

I HAVE READ DIANE GOULA'S PRIVACY NOTICE ON THIS DATE OF_____
AND KNOW THAT I MAY RECEIVE A COPY UPON REQUEST.

Signed_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic? **If you checked "NO," go to question 3.**	☐	☐
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

Continued on page 2 ➡

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of # 1a–i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a–i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a–e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	☐	☐	☐
b.	Your weight or how you look	☐	☐	☐
c.	Little or no sexual desire or pleasure during sex	☐	☐	☐
d.	Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e.	The stress of taking care of children, parents, or other family members	☐	☐	☐
f.	Stress at work outside of the home or at school	☐	☐	☐
g.	Financial problems or worries	☐	☐	☐
h.	Having no one to turn to when you have a problem	☐	☐	☐
i.	Something bad that happened recently	☐	☐	☐
j.	Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?

NO	YES
☐	☐

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medication for anxiety, depression, or stress?

NO	YES
☐	☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged** ☐ **No periods because pregnant or recently gave birth** ☐ **Periods have become irregular or changed in frequency, duration, or amount** ☐ **No periods for at least a year** ☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

		NO (or does not apply)	YES
b.	During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?	☐	☐
c.	If YES, do these problems go away by the end of your period?	☐	☐
d.	Have you given birth within the last 6 months?	☐	☐
e.	Have you had a miscarriage within the last 6 months?	☐	☐
f.	Are you having difficulty getting pregnant?	☐	☐