The Happiness Psychologist
Dr W F Diak III
28870 US Highway 19 N, Suite 357
Clearwater, FL 33761-2596

Important Policies Summary

This is a brief summary of some of our important policies. Please read it carefully.

Services Not Available

We do not provide the following services:

- Child custody evaluation
- Medical leave of absence documentation
- Family leave of absence documentation
- Social security disability evaluation
- Disability evaluation
- Workmen's compensation evaluation
- Attorney consultation
- Court appearance
- Legal reports

Most disability, compensation, and leave of absence forms can be completed by your primary care physician. If you have need of a psychologist for legal matters we will be happy to refer you to a forensic psychologist.

Confidentiality Limits

What you say in psychotherapy, your records, and your attendance are confidential except:

- When you give written permission to release information
- When your records are subpoenaed for legal reasons
- When reporting is required or allowed by law (e.g., suspected child abuse or neglect, suspected elder abuse, suspected abuse of a disabled person, extreme danger to self or others)
- As outlined in the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

Cancelled and Missed Appointments

- There is a $25 charge for appointments cancelled with less than 24 hours notice for any reason.
- There is a $50 charge for missed appointments for any reason.
- There is no charge for late cancellations due to severe weather.

We understand that clients sometimes need to cancel their appointment on short notice for legitimate reasons (e.g., accident, illness, employment, family emergency). Your appointment time is held specifically for you and we are unlikely to be able schedule another client during that time if you cancel on short notice. We value our clients. We have found that to remain viable as a practice we must charge for late cancellations and missed appointments. You are responsible for these charges, not your insurance company or employee assistance program. To avoid late cancellation and missed appointment charges, if you suspect that you may not be able to keep your appointment please call ahead.

Termination

You may terminate psychotherapy at any time. A final session or phone call is highly recommended for emotional closure.

Please ask Dr Diak for further clarification if you have questions regarding this summary.

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Client History Form

The information in this form will help me understand your situation. Complete answers will ensure you receive the most benefit from psychotherapy. Your replies will be held in confidence as required by law.

Date: _____ Name: _____ Birth Date: _____ Age: ___ Gender: []M []F

Street: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Messages OK? []Yes []No Cell: _____ Messages OK? []Yes []No

Work Phone: _____ Messages OK? []Yes []No Email: _____ Messages OK? []Yes []No

Driver's#: _____ State Issued: _____

Emergency Contact: _____ Relationship: _____ Phone:

_____

Insurance Company: _____ Group#: _____ ID#:

_____

SS#: _____

Employee Assistance Program: _____ Were you referred by a supervisor? []No []Yes, why? _____

Legally Responsible Party: _____ SS#: _____

Primary Physician: _____ Address: _____ Phone:

_____

Coordinate care with your physician? []Yes []No

How were you referred to The Happiness Psychologist?

Name: _____ Phone: _____ Address: _____

May we have your permission to thank this person for the referral? []Yes []No

Presenting Concern

What is the main concern that led you to consult with me?

_____

_____

When did this start?

_____

What have you been doing to

cope?_____

How successful has this been?

_____

Are you experiencing any current stressors?

_____

What would be your ideal result from psychotherapy?

_____

Education

	School	Location	Major	GPA	Dates
Elementary:	_____	_____	_____	_____	_____
Middle:	_____	_____	_____	_____	_____
High:	_____	_____	_____	_____	_____
College:	_____	_____	_____	_____	_____
Professional:	_____	_____	_____	_____	_____
Certificate/License:	_____	_____	_____	_____	_____

Have you had any history of difficulties at school? []No []Yes:

_____

Employment

Occupation: _____ []Self Employed []Full Time []Part Time []Student []Unemployed

Current Employer: _____ How long? _____

Prior Employers	Position	How Long	Why Left
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any history of difficulties at work? []No []Yes:

_____

Military Service (self or family): []No []Yes: Branch: _____ Position: _____ Dates: _____

Cultural/Ethnic/Racial Identity: _____ Spiritual/Religious Orientation:

_____

Relationships

Relationship Status: []Married []Divorced []Single []Cohabiting

Spouse/Partner's Name: _____ Spouse/Partner's Occupation:

_____

If married, or cohabiting, how long? _____ Spouse/Partner's Age: _____

If widowed, date of spouse/partner's death: _____ Cause of death:

_____

If separated/divorced: Date: _____ Reason:

_____

Children

Name	Birth Date	Age	Location	Name	Birth Date	Age	Location
_____	_____	___	_____	_____	_____	___	_____
_____	_____	___	_____	_____	_____	___	_____

Parents

	Birth Date	Age	Location
Mother	_____	___	_____
Father	_____	___	_____

If mother deceased, date, age, and cause of death: _____ _____

_____

If father deceased, date, age, and cause of death: _____ _____

_____

	Name	Age	Location
Boyfriend/Girlfriend	_____	_____	_____

Other Family Members

Name	Relationship	Age	Location
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

Friends

Name	Age	Location	Name	Age	Location
_____	___	_____	_____	___	_____
_____	___	_____	_____	___	_____

Pets

Name	Age	Species	Name	Age	Species
_____	___	_____	_____	___	_____

Living Arrangement

Where do you live? []Apartment []Condo []House []Other_____ []Own []Rent []Other_____

Who resides in your household?

Name	Relationship	Age	Name	Relationship	Age
_____	_____	___	_____	_____	___

_____ _____ ___ _____ _____ ___

_____ _____ ___ _____ _____ ___

_____ _____ ___ _____ _____ ___

Physical Health

How is your health in general?

_____

Date of most recent physical exam with lab work? _____ Results:

_____

HIV testing? []No []Yes: [ ]Neg [ ]Pos Hepatitis Testing? []No []Yes: [ ]Neg [ ]Pos

Do you currently have any illnesses? []No []Yes:

_____

History of serious illnesses?[]No []Yes:

_____

History of surgical operations? []No []Yes:

_____

History of head injury? []No []Yes Did you lose consciousness? []No []Yes:

_____

Other serious accidents or injuries? []No []Yes:

_____

Any allergies to medications, foods, or substances? []No []Yes:

_____

What types of reactions have you had?

_____

List current medications, vitamins, supplements used:

Med/Vita/Supplement Start-Stop Dates Dose Frequency Physician Condition

_____ _____-_____ _____ _____ _____

_____

_____ _____-_____ _____ _____ _____

_____

_____ _____-_____ _____ _____ _____

_____

_____ _____-_____ _____ _____ _____

_____

_____ _____-_____ _____ _____ _____

_____

_____ _____-_____ _____ _____ _____

_____

Do you use birth control? []No []Yes What form of birth control do you use?

_____

Do you engage in safe sex? []Always []Sometimes []Never []Abstinent

Do you have any sexual concerns? []No []Yes:

_____

Physical activities/exercise? How often?

_____

Sleep problems?

_____

Difficulties with diet, or eating? []No []Yes:

_____

Difficulties with maintaining your weight? []No []Yes:

_____

Developmental History

Was your mother exposed to stress, drugs, or dangerous substances while pregnant with you? []No []Yes

_____

_____

Were there any difficulties with your birth? []No []Yes:

_____

Did you have any difficulties with your physical development? []No []Yes:

_____

Substance Use

How often do you drink alcoholic beverages? []Never []Yes: (type, amount per use, frequency):

_____

_____

Have you ever tried to cut down on your drinking or drug use? []No []Yes:

When?_____

Have people ever annoyed you by criticizing your drinking or drug use? []No []Yes

Has anyone ever been annoyed at you because of your drinking or drug use? []No []Yes

Have you ever felt bad or guilty about your drinking or drug use? []No []Yes

Ever had a drink or a drug first thing in the morning to steady your nerves or get rid of a hangover? []No []Yes

Daily amount of caffeine? (coffee, tea, soda, energy drink, chocolate) []None []Yes (what, how much, how often):

_____ _____

_____

Do you use []tobacco, [] marijuana, []neither? (how much, how often):

_____

Former cigarette smoker? []No []Yes Frequency of past cigarette smoking: []Heavy []Moderate []Light

Do you use recreational or illegal drugs? []No []Yes (what, how much, how often):

_____ _____

_____

Has anyone in your family had drug or alcohol problems? []No []Yes (who, what):

_____

Ever injected drugs? []No []Yes Ever shared needles? []No []Yes

Mental Health

Social activities:

_____

Hobbies:

_____

Prior mental health counseling, psychotherapy, psychiatric, drug or alcohol treatment: []No []Yes: (provider name, dates):

_____

Purpose of treatment:

_____

Result:

_____

Prior hospitalization or emergency room treatment for psychiatric or emotional reasons:[]No []Yes: _____

_____

_____

Have you ever attempted to harm yourself? []No []Yes:

_____

Do you currently have any thoughts of harming yourself? []No []Yes:

_____

Has anyone in your family have emotional or psychiatric problems? []No []Yes:

_____

Has anyone in your family ever attempted to harm themselves? []No []Yes:

_____

Ever had a traumatic experience? []No []Yes:

_____

Ever been exposed to abuse? []child []domestic []elder []sexual []physical []verbal []assault []sexual assault Who was involved?

_____

Recent unusual amount of energy, productivity, or creativity? []No []Yes:

_____

Have you ever experienced a time in your life when you didn't need much sleep, but felt unusually energetic and productive? []No []Yes:

_____

Legal

Any current or anticipated legal problems? []No []Yes:

_____

Ever been: []fined []arrested []sued someone []or appeared in court? []No []Yes:

_____

Prior disability application, or planning to apply? []No []Yes: Disability: _____

Thank you for completing this form.

Couples Counseling Initial Intake Form

Name:_____ **Date**: _____

Name of Partner:_____

Relationship Status: (check all that apply)

□ Married
□ Separated
□ Divorced
□ Dating
□ Cohabitating
□ Living together
□ Living apart

Length of time in current relationship: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern
□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concern

Frequency
□ No occurrence
□ Occurs rarely
□ Occurs sometimes
□ Occurs frequently
□ Occurs nearly always

What do you hope to accomplish through counseling?

_____
_____
_____

What have you already done to deal with the difficulties?

_____
_____
_____

What are your biggest strengths as a couple?

_____
_____
_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No
If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? Yes □ No □
If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes □ No □ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes □ No □

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction

No satisfaction

Relationship over time

When you met/began dating ***Current***

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

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Website: http://www.palm-harbor-psychologist-diak.com/

Forms Acknowledgment

By my signature below I acknowledge that: I have read each of the following forms, had sufficient time to consider them carefully, understand the contents, and asked any questions that I had. I agree to the conditions detailed in each of the forms. I have received copies of each of the forms. **Initial only the forms you have received.**

1. Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information ___ Initial Here
2. Professional Services Contract ___ Initial Here
3. Consultation Information ___ Initial Here
4. Consent For Treatment Of A Minor ___ Initial Here
5. Consent To Evaluation ___ Initial Here
6. Psychotherapy Services Agreement For Collaterals ___ Initial Here

_____ _____
Signature of client or legal representative Date

_____
Printed name of client or legal representative

_____ _____
Signature of parent or guardian Date

_____
Printed name of parent or guardian

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Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
I may use or disclose your *protected health information* (*PHI*), for the purposes of *treatment*, *payment*, and *health care operations* with your consent. Examples of PHI in your record are your history, reasons you came for treatment or evaluation, diagnosis, treatment plan, progress notes, other health care providers' records, test scores & school records, medication information, legal matters, billing, and insurance information. To help clarify these terms, here are some definitions: *PHI* refers to information in your health record that could identify you. *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. *Use* applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Your Authorization
I may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An *authorization* is written permission above and beyond a general consent, and only permits specific disclosures to specific individuals. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *Psychotherapy notes* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke authorizations of PHI or psychotherapy notes at any time, provided that each revocation is in writing. You may not revoke an authorization if I have already relied on that authorization, or if the authorization was obtained as a condition of obtaining insurance coverage in which the insurer has the legal right under the policy to contest the claim.

III. Uses and Disclosures Requiring Neither your Consent Nor your Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the Florida Department of Children and Families.
- **Adult and Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I must report the information to the Florida Department of Children and Families.
- **Health Oversight:** If the Florida Department of Health or Florida Board of Psychology issue a subpoena, I may be compelled to testify before the FDH or FBP and produce your relevant records and papers.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- **Serious Threat to Public Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim, yourself, or the public and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.
- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, or the Division of Workers' Compensation.

IV. Patient's Rights and Psychologist's Duties
Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you might request that I call you only at a certain phone number, or send your bills to specific address.
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of the PHI in your mental health and billing records that was used to make decisions about you, for as long as this information is maintained. However, I am not required to allow you to inspect or

obtain a copy of your *psychotherapy notes*. These are not part of your PHI. I am required to provide a summary of my psychotherapy notes to you if you request it in writing. There may be an associated fee. I am not required by Florida law, unless subject to a court order, to release any written information, or a report, on a minor child to anyone, including a parent, if in my opinion it would not be in the best interest of the child. I may deny your access to PHI under certain other circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request process.

- **Right to Amend:** You have the right to request an amendment of PHI after reviewing it, for as long as the PHI is maintained in the record. However, the law does not require me to make a change if I do not agree with it. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of your PHI and to provide you with this notice of my legal duties and privacy practices regarding PHI.
- I reserve the right to change the privacy policies and practices described in this notice and to make the new notice provisions effective for all the PHI that I maintain. Unless I notify you of such changes, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post the revised version on my website. At your request I will provide you with a copy by mail or electronically.

V. Questions and Complaints
If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. W. F. Diak III at (727) 280-6569.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Dr. W. F. Diak III at the above address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Filing a complaint will not affect the services you receive from this office.

VI. Effective Date
This notice takes effect February 2, 2011.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

The federal government mandated as of April 14, 2003 that all patients are to receive from their health care providers a Notice regarding the protection of their private health care information (PHI). PHI is information that is used for treatment, payment, and health care operations. Your signature below acknowledges that you have reviewed and understood my Notice of Privacy Practices.

The Notice of Privacy Practices contains information about:

- How your PHI may be used and disclosed for *treatment*, *payment*, and *health care operations*. These terms are defined in the Notice.
- Which uses and disclosures require authorization from you and which do not.
- How you may revoke an authorization you have made.
- Certain rights you have to restrict use and disclosure of your PHI, to receive confidential communications by alternative means, at alternative locations, to inspect, copy, amend your records, and to have an accounting of disclosures.
- My duties to protect the privacy of your PHI, my right to change the policies in the Notice, and how I will inform you of changes.
- Restrictions you or I might place on the use and disclosure of your PHI.
- How you can file a complaint about suspected violations of your privacy rights or about decisions regarding access to your PHI.
- In the future, I may modify the Notice of Privacy Practices. You may obtain a copy of the latest revision from my website or by requesting one from me.

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Professional Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you discuss. There are many different methods I may use to help you with the problems that you want to address. Psychotherapy is not the same as a visit to a medical doctor. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on the things we talk about, both during our sessions and between visits.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as: sadness, guilt, anger, frustration, loneliness, and anxiety. On the other hand, psychotherapy has also been shown to have powerful benefits for the people who go through it. Therapy often leads to better relationships, solutions to specific problems, significant reductions in feelings of distress, and an improved sense of well-being. But there are no guarantees of what you personally will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with whether you feel comfortable working together. Therapy involves a significant commitment of time, money, and energy, so you should exercise care in your selection of a therapist. If you have questions about my procedures, we should discuss them as they arise. If you would like, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

It is important to be familiar with the credentials of the individual treating you. Please feel free to inquire about my training and credentials. I am a licensed counseling psychologist. I do not prescribe medication.

MEETING TIMES AND CANCELLATIONS

I normally conduct an evaluation that lasts from 1-2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your therapy goals. If psychotherapy is begun, I will usually schedule one 50-minute session (i.e., one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. You are responsible for coming to your sessions on time and at the time we have scheduled. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation.** Canceled appointments are not paid for by insurance companies. If you are late, we will end on time and not run over into the next client's session.

PROFESSIONAL FEES

Psychotherapy, Counseling, Coaching

My hourly fee for psychotherapy, counseling, and coaching services is $160 for the initial session, and $120 for follow up sessions, unless otherwise specified and mutually agreed upon. In addition to weekly appointments, I charge this amount for most other services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me (except as noted below).

Psychological Testing and Evaluations

Fees for psychological testing and formal psychological evaluations such as IQ assessments, personality testing, and other psychological assessments vary based upon complexity, the psychological tests used (if any), and the purpose of the evaluation. You will be informed of the costs associated with such an evaluation prior to any such services being rendered.

Forensic and Legal Services
Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding. Additionally, any services rendered as part of a legal proceeding, such as: disability hearings, expert witness testimony, divorce proceedings, and custody proceedings are billed at the rate of $250 per hour. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. All payments for reports, legal consultation, and evaluations must be paid in full prior to report submission or court testimony.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. There is a returned check fee of $40.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I may use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. If a collection agency is used, its costs will be charged to you. In most collection situations, the only information I release regarding a client's treatment is his or her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT
In order for us to set reasonable treatment goals and priorities, it is important to evaluate what resources you have to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled- however, **you, not your insurance company, are responsible for the full payment of my fees.**

Due to the rising costs of health care, insurance benefits have become increasingly complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed health care" plans such as HMOs and PPOs are often limited to short term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short term therapy, some clients feel they need more services after their insurance benefits end.

With the exception of the specific insurance plans that I accept, all fees are expected to be paid in full at the time service is rendered. Some insurance policies include coverage for "out of network" care. If so, I will provide you with the necessary documents, forms, or other information needed for you to submit to your insurance company for possible reimbursement. However, please be aware that most insurance companies require you to obtain prior authorization for mental health services and may not reimburse you for services they have not authorized.

You should be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis in order for you to receive reimbursement. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. I will never release any information to your insurance company without your consent. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME
I am often not immediately available by telephone, but you may leave me a voicemail message at any time. Please keep in mind that I do not answer the phone when I am with a client. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. I typically return calls in the evening. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the local crisis center, or go to the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. For non-urgent communication you may also contact me through standard email at TheHappinessPsychologist@gmail.com, but be aware that I am often unable to check this email account until late in the evening, so please call if you are canceling an appointment or otherwise need to speak with me in a timely fashion. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

IMPORTANT SECURE COMMUNICATIONS NOTICE
Please be aware that standard email is an inherently insecure method of communication that may be read by third parties

during and after transmission. If you want to insure that your communication is secure you should use encrypted email, telephone, or fax. I will be happy to communicate with you using encrypted email, if you request it. To communicate with me via encrypted email you may email me at Dr.Diak@Hush.com after you either give me a password to use, or after you set up a free Hushmail account. If you would like to set up a secure encrypted email account you may do so for free at Hushmail.com.

According to the Hushmail website:

> Hushmail is a web-based email service that lets you send and receive email in total security using OpenPGP standard algorithms. These algorithms, combined with Hushmail's unique key management system, provide unrivaled levels of security. Hushmail's encryption is automatic, transparent, and seamless - no special computer skills are required.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests. In certain situations I may conduct a review meeting without charge.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to waive their access to your records. If they agree, I will only provide them with general information about our work together, unless I believe there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify your parents of my concern. I will provide your parents with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and will do my best to handle any objections you may have.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work with your written permission. But there are some exceptions:

1. In most legal proceedings you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.

3. If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include: notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm him or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are complex, and I am not an attorney.

CANCELLATIONS AND MISSED APPOINTMENTS

Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. My voicemail has a time and date stamp which will keep track of the time of cancellation. Please understand that this appointment time has been reserved for you and it is very likely that another client would have liked to have had that appointment had it been available. I cannot keep my practice viable if I do not enforce this policy. Therefore, if you miss an appointment or fail to provide 48 hours advance notice as outlined in this section you must pay for the missed appointment at your next visit or additional appointments will not be scheduled. If I am unable to attend a scheduled appointment and fail to provide you with

48 hours notice, then you will not be charged for your next session. The same emergency exception applies for me for circumstances out of my control.

Your signature on the Forms Acknowledgment form indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT CONSENT TO PSYCHOTHERAPY
I have read this statement, had sufficient time to be sure that I have considered it carefully, asked any questions that I needed to, and understand it. I am over the age of eighteen. I consent to the use of a diagnosis in billing when required. I agree to pay the fee of $120.00 per session, unless otherwise specified and mutually agreed upon. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Dr. W. F. Diak III. I know I can end this therapy at any time I wish, and that I can refuse any requests or suggestions made by Dr. Diak. I have received a copy of this document.

The Happiness Psychologist
Dr W F Diak III
28870 US Highway 19 N, Suite 357
Clearwater, FL 33761-2596
(727) 280-6569

License: PY8129 Website: palm-harbor-psychologist-diak.com Email: TheHappinessPsychologist@gmail.com

PSYCHOTHERAPY SERVICES AGREEMENT FOR COLLATERALS

INTRODUCTION

I want to thank you for accepting the invitation to assist in (client) _____'s psychotherapy. Your participation is important, and is sometimes essential to the success of the treatment. This document is to inform you about the risks, rights and responsibilities of your participation as a collateral participant.

WHO IS A COLLATERAL?

A collateral is usually a spouse, family member, or friend, who participates in psychotherapy to assist the identified client. The collateral is not considered to be a client and is not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to clients, and the privacy of the relationship is given legal protection. My primary responsibility is to my client and I must place their interests first. You also have less privacy protection.

THE ROLE OF COLLATERALS IN PSYCHOTHERAPY

The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the client, to provide information to the therapist and never attend another session. In another case a collateral might attend all of the client's psychotherapy sessions and his/her relationship with the client may be a focus of the treatment. We will discuss your specific role in the treatment at our first meeting and other appropriate times.

BENEFITS AND RISKS

Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the client. While your participation can result in better understanding of the client or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

MEDICAL RECORDS

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified client's chart. The client has a right to access the chart and the material contained therein. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated. You have no right to access that chart without the written consent of the identified client. You will not carry a diagnosis, and there is no individualized treatment plan for you.

FEES

As a collateral you are not responsible for paying for my professional services unless you are financially responsible for the client.

CONFIDENTIALITY

The confidentiality of information in the client's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the identified client specifically authorizes me to do so. There are some exceptions to this general rule:

- If I suspect you are abusing or neglecting a child or a vulnerable adult, I am required to file a report with the appropriate agency.
- If I believe that you are a danger to yourself (suicidal) I will take actions to protect your life even if I must reveal your identity to do so.
- If you threaten serious bodily harm to another I will take necessary actions to protect that person even if I must reveal your identity to do so.
- If you, or the client, is involved in a lawsuit, and a court requires that I submit information or testify, I must comply.
- If insurance is used to pay for the treatment, the clients insurance company may require me to submit information about the treatment for claims processing purposes or for utilization review.

You are expected to maintain the confidentiality of the identified client (your spouse, friend, or child) in your role as a collateral.

DO COLLATERALS EVER BECOME A FORMAL CLIENT?

Collaterals may discuss their own problems in psychotherapy, especially problems that interact with issues of the identified client. The therapist may recommend formal psychotherapy for a collateral. These are some examples of when this might occur.

- It becomes evident that a collateral is in need of mental health services. In this circumstance the collateral needs to have a psychologist, diagnosis, and chart records kept.
- Parents, being seen as collaterals as their child is being treated, need couples psychotherapy to improve their relationship so they can function effectively as parents.

Most often, but not always, your psychologist will refer you to another psychologist for treatment in these situations. There are two reasons the referral may be necessary:

- Seeing two members of the same family, or close friends, may result in a dual role, and potentially cloud the psychologist's judgement. Making a referral helps prevent this from happening.
- The psychologist must keep a focus on the original primary task of treatment for the identified client. For example, if the psychologist started treating a child's behavioral problem, then takes on couples counseling with mom and dad to address their relationship problems, the original focus of psychotherapy with the child may be lost. A referral helps the psychologist to stay focused.

One exception to these guidelines is when a family therapy approach can be effectively and ethically used to treat all members of the family, or each of the couple.

RELEASE OF INFORMATION
The identified client is not required to sign an authorization to release information (Authorization Form) to the collateral when a collateral participates in psychotherapy. The presence of the collateral with the consent of the client is adequate. This provides some assurance that full consent has been given to the psychologist for the client's confidential information to be discussed with the collateral in psychotherapy. The Authorization Form is helpful to the psychologist on those occasions when receiving a telephone call from a collateral or when the psychologist calls a collateral for one reason or another. In most instances the psychologist cannot take a call from a collateral without an Authorization Form.

PARENTS AS COLLATERALS
Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified client is not a minor.

- In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But parents also need to know certain information about the treatment. For this reason, we need to discuss and agree about what information will be shared and what information will remain private. I generally require a written contract signed by both you and your child/children concerning access to a child's record and once that contract is made, I will treat it as legally binding, although it sometimes may be overridden by a judge. In general, I believe that parents should be informed about the goals of treatment and how the treatment is going and whether the child comes to his/her appointments. At the end of treatment, I may prepare a summary for the parents. In addition, I will always inform you if I think that your child is in danger or if he/she is endangering others. One of our first tasks is to discuss and agree on our shared definition of dangerousness so we are all clear about what will be disclosed.

- If you are participating in psychotherapy with your child, you should expect the psychologist to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child.

SUMMARY
If you have questions about psychotherapy, my procedures, or your role in this process, please discuss them with me. Remember that the best way to assure quality and ethical treatment is to keep communication open and direct with your psychologist. By signing below you indicate that your have read and understood this document.

_____ _____
Signature Date

_____
Print Name

Last Updated: 5-1-14

The Happiness Psychologist
Dr W F Diak III
28870 US Highway 19 N, Suite 357
Clearwater, FL 33761-2596

Assignment of Benefits

Print Name of Insured: _____

Social Security Number: _____ HIC#: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Dr. W. F. Diak III for all services provided to me. I understand that Dr. W. F. Diak III accepts assignment of payments by Medicare as payment in full, and that I am responsible for paying the deductible and coinsurance amount if applicable.

I authorize the release of any medical or other information necessary to determine these benefits, or the benefits payable for related services, to my insurance company and its agents. A copy of this authorization will be sent to my insurance company if requested. This assignment will remain in effect indefinitely, or until cancelled by the insured. The original will be kept on file by Dr. W. F. Diak III.

I understand that I am financially responsible to Dr. W. F. Diak III for any charges not covered by health care benefits. It is my responsibility to notify Dr. W. F. Diak III of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Dr. W. F. Diak III and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for payment for all services received.

Print Client Name: _____

Client Signature : _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

Couples Counseling Initial Intake Form

Name:_____ **Date**: _____

Name of Partner:_____

Relationship Status: (check all that apply)

□ Married
□ Separated
□ Divorced
□ Dating
□ Cohabitating
□ Living together
□ Living apart

Length of time in current relationship: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern
□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concern

Frequency
□ No occurrence
□ Occurs rarely
□ Occurs sometimes
□ Occurs frequently
□ Occurs nearly always

What do you hope to accomplish through counseling?

_____
_____
_____

What have you already done to deal with the difficulties?

_____
_____
_____

What are your biggest strengths as a couple?

_____
_____
_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No
If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? Yes □ No □
If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes □ No □ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes □ No □

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction

No satisfaction

Relationship over time

When you met/began dating ***Current***

Thank you for completing this. Please bring this with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.