Ashley Hoffman, Psy.D
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Dr. Hoffman and Valley Christian Counseling Welcomes You

We appreciate your selecting us and having confidence in our staff. We want you to feel comfortable coming to Valley Christian Counseling and to accomplish this we have prepared this introduction. Although this document can seem long and complex, it is very important that you read it carefully and complete all sections before our first session. We can discuss any questions you may have at that time. Please continue to ask any questions or voice concerns throughout the course of treatment so that our professional relationship will be open and satisfying for all. When you sign this document, it will also represent an agreement between you and Dr. Hoffman. You may revoke this Agreement in writing at any time.

Appointments

Psychotherapy appointments are normally 50 minutes in duration, however longer sessions are also available. After your intake appointment, future appointments will be scheduled as determined between you and your clinician. Clients are seen by appointment only. To change or cancel an appointment, we require at least a 24-business hour notice to our office for any cancellations. This will help us to schedule those waiting for appointments and for you to avoid being charged for the time that was reserved for you. **Clients who cancel without a 24-hour notice or do not attend their appointment will be charged the full session fees.** If your appointment is on a Monday, and you leave a message on the machine over the weekend, then that does not constitute 24-hour notice. Insurance does not pay for late cancellations or missed appointments. Confirmation calls are done as a courtesy to patients; however, there are times we cannot make them. Please do not rely on our call.

Emergencies

If you experience an emergency during or after hours, you should seek immediate help by calling 911, Helpline (539-1000 or 539-3424), the mental health center (533-1970), your primary care physician, or one of the hospital emergency rooms for assistance as needed and then alert your clinician at your earliest convenience.

Financial Agreement

I, (your name) _____ understand that Dr. Hoffman does not file insurance and is not in network for any private insurance providers. She cannot determine if or what you will be reimbursed for psychological services. That is between you and your insurance provider. If you plan to file an insurance claim on psychological services, please contact your insurance provider before your first visit to verify your mental health benefits as pre-certification or authorization may be required. You will be provided a complete itemized statement at the time of service that contains all necessary information needed so that you can bill your insurance directly. Please be prepared to pay for your session fee of $165 in full at the beginning of each appointment. We accept cash, check, or credit card. Cancellations of appointments without a 24-hour notice and no-shows of appointments will be charged the full session rate.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the disclosure of otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is their name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

- If a letter or other special correspondence is requested/required, preparation time for processing the request may be billed at the clinician's usual hourly rate.
- Review of past therapeutic documentation (i.e. treatment, history, discharge summaries, etc.) letters, journals, or personal writings forwarded to the clinician for reading and telephone correspondence to and from authorized sources may be subject to billing at the usual hourly rate and is regarded as the client's personal financial responsibility (not covered by insurance).

- During the course of treatment, off-site consultation is sometimes requested. School consultations, team meetings, and hospital consultations are billed at the usual hourly rate, including travel time.
- **Clients are discouraged from having their clinician subpoenaed.** All court related work is billed at $250/hour. This is a non-insurance charge. The client will be responsible for payment which includes: phone calls, filing documents with the court, pre-court record review, pre-court case formulation, depositions, consultations with attorneys, court appearances, in court (testimony) time, and time for travel and "waiting," and total time out of the office (departure until return). The minimum charge for a court appearance is $1500. A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500). Even though you are responsible for the testimony fee, it does not mean that the clinician's testimony will be solely in your favor. The clinician can only testify to the facts of the case and to their professional opinion. Patients will be asked to sign a release of information and agreement for court appearances, if these services are required.

***I am looking for a clinician to assist me in court related issues: NO _____ YES_____**

I have been given the opportunity to discuss these policies and to ask for clarification. I have read and agree with all of the above information. I understand that I will be responsible for charges and will pay for services as rendered regardless of amounts, if any, reimbursed to me by my insurance company. My signature below constitutes an understanding of and agreement to the terms and conditions above.

_____ _____

Client or Legal Guardian's signature Date

Clinical Record

Professional laws and standards require that a clinical record of psychotherapy services be maintained for all treatment provided. The client record remains the property of the clinician. If client is a minor, his/her records will be kept for seven years after termination or after 18 years of age, whichever comes chronologically later. Patients have the right to request that a record is amended; to request restrictions on what information from your clinical record is disclosed to others; to request an accounting of disclosures that you have neither consented to nor authorized; to determine the location to which protected information disclosures are sent; and to have any complaints you make about these policies and procedures recorded in your records. Valley Christian Counseling is not a HIPAA covered entity. I am happy to discuss any of these rights with you.

Confidentiality and Disclosure Statement

The confidentiality of psychotherapy services provided by Dr. Hoffman is protected by professional ethics and law. Unless you grant written permission, we will neither inform anyone that you are receiving services, nor will we disclose personal information provided. Legal and ethical exceptions exist. If you would like for information from your clinical record to be sent to a third party (i.e., physician, therapist, attorney, etc.) you must *first* sign a Release of Authorization form provided by our office. A fee may be required before records are forwarded.

PATIENTS UNDER 14 YEARS OF AGE who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in imminent danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Custody and Consent to Treatment

*If the child's parents are divorced then a copy of the most recent custody agreement is required to receive treatment. This must be brought to the first session to document proof of parental right to consent to the minor's treatment. If both parents have rights to consent to the minor's treatment then I am required to obtain the other parent's permission and inform them of

my involvement. It is NOT your therapist's role to conduct a custody evaluation, or determine whether a parent is "fit" or not, recommend one parent over another, nor focus on reunification of a child and parent. Your therapist will not testify in court about custody issues, unless compelled by a court. For children with divorced parents, your therapist expects the parents to communicate with each other about services, decide who will schedule appointments, who will bring the child to treatment, etc. It is not appropriate for the therapist or the child to act as a messenger between parents.

I understand that I am required to prove parental right to consent to the minor's treatment. I understand that my child's other parent may be contacted regarding consent for treatment.

_____ _____

Client or Legal Guardian's Signature Date

Limits On Confidentiality

The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements. There are other situations that require that you provide written advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together. I will note all consultations in your Clinical Record.
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling and billing. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also may have contracts with other businesses such as an accounting firm or attorney. I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the patient's employer or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment.

- If I know or suspect that a child under the age of 18 has been abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

- If I know that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If a clear and immediate threat of serious physical harm to an identifiable victim is communicated by a patient then I am required to communicate confidential information to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities.

I hereby acknowledge that these limitations on confidentiality have been read by me and/or explained to me and I agree to abide by them. I have been given the opportunity to discuss these concepts and conditions and to ask for clarification. I understand that my consent to treatment may be withdrawn by me at any time without prejudice.

_____ _____

Client or Legal Guardian's Signature Date

Client's Rights

You, the client, have the right to:

- Receive respectful treatment that will be helpful to you without discrimination
- Be informed about techniques, intervention strategies and procedures, or any aspect that might not be clear or understood regarding treatment
- Be informed and inquire about diagnosis, methods of assessment, and the goals of treatment
- Accept or decline treatment (except in emergency situations or when ordered by a judge or Federal/State authority)
- Receive an explanation of services offered, your time commitments, fees, and billing policies prior to receipt of services in the Good Faith Estimate provided in this paperwork,
- Be informed of the limitations of your therapist's practice and receive a referral to another professional if your presenting concern is outside of your provider's scope of practice
- Seek alternative psychotherapy services and be provided with an appropriate referral
- Discuss, question, and participate in hospital, residential placement, half-way or quarter-way treatment decisions
- Ask for and receive information about the clinician's qualifications, including license, education, training, experience, membership in professional groups, and specializations
- Refuse to answer any question or give any information you choose not to answer or give
- Know if your clinician will discuss your case with others
- Ask that the clinician inform you of your progress
- A safe treatment setting, free from sexual, physical, and emotional abuse. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate
- Report suspected immoral or illegal behavior.
- The right to terminate the counseling relationship at any time without any moral, legal, or financial obligations other than those already incurred.

Other Considerations

Smoking is not allowed inside the facilities. Possession of illegal substances, alcohol, firearms, or weapons is prohibited on our premises. Being under the influence of drugs or alcohol is prohibited. If we suspect that you are in violation of these rules, or any other laws, you will be asked to leave, and /or appropriate authorities will be notified. In an effort to protect confidentiality and maintain professional boundaries, Dr. Hoffman will not be friends with or connect with clients or their family members on social media platforms either during treatment or afterwards.

Our psychologist, therapists and psychiatrist are experienced, independently licensed and certified in their respective specialty areas. Each practitioner operates as the sole proprietor of his or her practice. My signature below acknowledges my understanding and acceptance that each practitioner here operates as the sole proprietor of his or her practice. I agree to hold harmless all other practitioners at this site from the actions of my psychologist or therapist.

_____ _____

Client or Legal Guardian's signature Date

IDENTIFYING INFORMATION Today's date: _____
Child's name: _____ Date of birth: _____
Age: _____ Sex: _____Grade: _____Race/Ethnicity:_____
Religious Affiliation: _____Place of Worship:_____
Person(s) completing this form: _____ Relationship to minor: _____
How did you hear about us: _____
Child's Custodian/Guardian(s): _____
Child's Home Address: _____
City _____ State _____ Zip Code _____
Child/teen's phone # (if applicable): _____Other Phone (specify type): _____
Is it OK to contact you/child at home? □ yes □ no OK to leave a message? □ yes □ no
Special instructions? _____
Emergency Contact Name: _____ Relationship to Child: _____
Telephone: _____ Other Phone (specify type): _____

MOTHER'S INFORMATION
Mother's name: _____ Home phone: _____
Address (if different): _____
Religious affiliation: _____ Highest Grade Completed: _____
Marital/relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed or □ Other: _____
Employment status (Check all that apply):
□ employed □ retired □ disabled □ student □ homemaker □ unemployed
If/When employed, what type of work does mother do? _____
Current employer is: _____
Years on Current Job: _____ Business Phone: _____
Is it OK to contact mother at work? □ yes □ no OK to leave a message? □ yes □ no
Special calling instructions? _____

FATHER'S INFORMATION
Father's name: _____ Date of birth: _____ Home phone: _____
Address (if different): _____
Religious affiliation: _____ Highest Grade Completed: _____
Marital/relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed or □ Other: _____
Employment status (Check all that apply):
□ employed □ retired □ disabled □ student □ homemaker □ unemployed
If/When employed, what type of work does father do? _____
Current employer is: _____
Years on Current Job: _____ Business Phone: _____
Is it OK to contact father at work? □ yes □ no OK to leave a message? □ yes □ no
Special calling instructions? _____

STEP-PARENT'S INFORMATION
Step-parent's name: _____ Date of birth: _____ Home phone: _____
Address (if different): _____

Religious affiliation: _____ Highest Grade Completed: _____
Marital/relationship status (Check all that apply):
□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed or □ Other: _____
Employment status (Check all that apply):
□ employed □ retired □ disabled □ student □ homemaker □ unemployed
If/When employed, what type of work does step-parent do? _____
Current employer is: _____
Years on Current Job: _____ Business Phone: _____
Is it OK to contact step-parent at work? □ yes □ no OK to leave a message? □ yes □ no Special calling instructions? _____

REASON FOR SEEKING TREATMENT
Please briefly describe the problems your child is experiencing: _____
_____
_____
_____
What has happened to cause you to seek help NOW?_____
_____
_____
_____
What do you hope to be able to do or achieve as a result of treatment? _____
_____
_____
_____
What do you consider to be other stresses in your child/adolescent's life? _____
_____
_____
_____

HISTORY OF THE PROBLEM
When did your child first start experiencing the problem(s) that brought you here today?_____
_____
How often does the problem occur? _____
How long does it last? _____
Does your child/adolescent have any thoughts of harming him/herself? Y N
Has your child/adolescent ever attempted to harm him/herself? Y N If yes, please explain:
_____
Does your child/adolescent have any thoughts of harming someone else? Y N
Has your child/adolescent ever attempted to harm someone else? Y N If yes, please explain:
_____
Has your child/adolescent ever received counseling, psychological or psychiatric services? Y N
If yes, please specify providers, diagnoses made, and dates of service:
_____
_____
_____
_____

What concerns were addressed in therapy?_____
_____
Was this experience helpful (explain)? _____

DEVELOPMENTAL AND MEDICAL HISTORY

Developmental Milestones	*Age Reached Milestone*	*In your opinion was this late, on time, or early*
Slept through the night		
Lifted head		
Crawled		
Used gestures to talk		
Talked using baby jargon		
Talked with two real words		
Talked with phrases		
Walked		
Accepted/showed affection		
Toilet trained		

Was the child the result of a full-term pregnancy? Y N If Preterm, by how many weeks? _____
During the pregnancy, did the mother use the following (please circle all that apply):
None Alcohol Tobacco Drugs (please specify): _____
Were there any problems with the delivery? Y N (Comments) _____
Birth Weight: _____ Did the child experience any medical problems at birth? Y N
If Yes, please explain:
_____
_____

Does or did the child experience any delay or concern in any of the following areas?

Gross Motor Skills (crawling, walking independently, balance, coordination)	Y	N
Fine Motor Skills (pencil/paper coordination, tying shoes, cutting with scissors)	Y	N
Expressive Language (using single words, phrases, sentences, articulation)	Y	N
Receptive Language (understanding others' language and communication)	Y	N
Social Skills/Interaction (quality of interactions, interest in interacting, etc.)	Y	N
Sensory/Environmental Sensitivities (to sounds, textures, temperatures, etc)	Y	N
Intense Preoccupation with Unusual Objects (such as lights, fans, motors, etc)	Y	N

*If "Yes" to any of the above, please specify:
_____
_____
_____
_____

Has he/she ever had any head injuries? Y N Specify dates and nature of head injuries:
_____
_____

Describe sleep patterns or problems: _____
_____

Who is the child's primary medical provider/health care organization?

_____

Date of Most Recent Visit:_____

Any medical specialist involvement? (Please specify providers and dates of most recent visits)

_____

_____

Does the child have any medical concerns? Y N Comments: _____
When was the child's most recent hearing and vision testing? _____
Are there any identified vision or hearing problems? Y N Comments: _____
Does the child have any allergies? Y N Comments: _____
Approximate hours a day spent on electronics:_____ Playing video games:_____

Please list all currently prescribed medications and over-the-counter medications and supplements; the reason prescribed; the duration; and effect by completing the following table.

Name of medication	Reason prescribed	Date started	Date ended/ reason for stopping

FAMILY HISTORY

Please List All Individuals Currently Residing **Within** the Child's Home:

Name Relationship to Child Age

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please List Immediate Family Members Currently Residing **Outside** the Child's Home:

Name Relationship to Child Age

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

Is there a familial history of any of the following concerns with any biologic relatives (please include immediate family members and extended relatives)?

			Relationship to Child/Adolescent
Autism Spectrum	Y	N	_____
Learning Disorder	Y	N	_____
Mental Retardation	Y	N	_____
Eating Disorder	Y	N	_____
Depression	Y	N	_____
Bipolar Disorder/Manic-Depression	Y	N	_____
Anxiety Disorder	Y	N	_____
Obsessive-Compulsive Disorder	Y	N	_____
ADD/ADHD	Y	N	_____
Schizophrenia or Psychotic Disorder	Y	N	_____
Alcohol/Drug Problems	Y	N	_____
Legal Problems	Y	N	_____
Other (please specify)	Y	N	_____

Are the child's parents/guardians divorced? Y N
If the child's parents are separated or divorced, for how long, and how old was the child at the time of the separation? _____
What is the placement/custody arrangement? _____
How often does the other parent see this child?
__ Weekly or more often __ Once or twice a month __ Few times a year __ Never

Has the child ever required foster care placement? Y N
If "Yes", at what age(s) did this occur and for how long? _____

Is the child/adolescent adopted? Y N
Is the child aware that he/she is adopted? Y N
If "Yes", at what age was the child adopted? _____

CHILD'S EDUCATION HISTORY
Describe any difficulties or problems your child is having in school: _____
_____
_____
_____
_____

School (name, address)	Grade	Age	Teacher	GPA

Has the child ever received special education services? Y N Grade:_____
Does your child have a history of receiving early intervention services? Y N
If Yes, please specify: _____

Has your child received any of the following specialized services (circle all that apply)
Physical Therapy Occupational Therapy Speech and Language
Specify providers and dates: _____

Has he/she ever been evaluated by a school psychologist: Y N
If Yes, please list provider and dates: _____

ADDITIONAL SOCIAL HISTORY
Has the child/adolescent experienced any type of abuse: Y N
Please check all that apply:
_Observing Chronic Parental Conflict
_Observing Domestic Violence between Parents/Guardians
_Emotional Abuse
_Physical Abuse
_Sexual Abuse
_Please Specify: _____

If there is a history of abuse, was the abuse reported to authorities? Y N
Please provide dates and authorities involved: _____

Are there any concerns that the child/adolescent has engaged in alcohol or other drug use? Y N
If so, please specify substances, suspected use frequency, suspected dates of use:
_____
_____

Are you concerned about your child/adolescent's choice of friends/peer group? Y N
Do you believe the friends/peer group to be a positive, neutral, or negative influence on your child?
_____

Has the child/adolescent had any legal problems? Y N
If so, please specify charges, authorities involved, and dates:
_____

Does your child/adolescent demonstrate any sexual concerns/behaviors? Y N
If so, please specify: _____

Is your child involved in any extracurricular activities, such as school sports, music programs, clubs or religious organizations? Y N If yes, please describe:
_____
_____
_____

Please list three of your child/adolescent's strengths:
1. _____
2. _____
3. _____

Please list three of your child/adolescent's weaknesses:
1. _____
2. _____
3. _____

Please indicate if the following is current, past neither or both for your child/adolescent. Please indicate the frequency using the following scale: Never (1); Sometimes (3); Almost Always (5)

Psychosis Symptoms	When	Frequency
Hearing voices	Current / Past	1 2 3 4 5
Seeing things	Current / Past	1 2 3 4 5
Paranoia	Current / Past	1 2 3 4 5
Special powers	Current / Past	1 2 3 4 5
TV, Radio, News talks to you or about you personally	Current / Past	1 2 3 4 5
ADHD Symptoms	**When**	**Frequency**
Overly active	Current / Past	1 2 3 4 5
Constantly in motion	Current / Past	1 2 3 4 5
Constantly talking	Current / Past	1 2 3 4 5
Constantly interrupting	Current / Past	1 2 3 4 5
Annoying to peers	Current / Past	1 2 3 4 5
Annoying to adults	Current / Past	1 2 3 4 5
Constantly distracted	Current / Past	1 2 3 4 5
Forgetful	Current / Past	1 2 3 4 5
Inattentive	Current / Past	1 2 3 4 5

Anxiety Symptoms	When	Frequency
Excessive worrying	Current / Past	1 2 3 4 5
Muscle stiffness	Current / Past	1 2 3 4 5
Panic attacks	Current / Past	1 2 3 4 5
Avoiding things	Current / Past	1 2 3 4 5
Unwanted fears	Current / Past	1 2 3 4 5
Unwanted rituals	Current / Past	1 2 3 4 5
Unwanted habits	Current / Past	1 2 3 4 5
Procrastination	Current / Past	1 2 3 4 5

Depression Symptoms	When	Frequency
Depressed mood	Current / Past	1 2 3 4 5
Loss of pleasure	Current / Past	1 2 3 4 5
Loneliness	Current / Past	1 2 3 4 5
Decreased appetite	Current / Past	1 2 3 4 5
Increased appetite	Current / Past	1 2 3 4 5
Poor concentration	Current / Past	1 2 3 4 5
Crying spells	Current / Past	1 2 3 4 5
Suicide thoughts	Current / Past	1 2 3 4 5
Homicide thoughts	Current / Past	1 2 3 4 5
Isolation	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Weight loss	Current / Past	1 2 3 4 5
Weight gain	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5

Mania Symptoms	When	Frequency
Increased energy	Current / Past	1 2 3 4 5
Racing thoughts	Current / Past	1 2 3 4 5
Rapid speech	Current / Past	1 2 3 4 5
Less than 4 hours sleep per night	Current / Past	1 2 3 4 5
Euphoria	Current / Past	1 2 3 4 5
Invincibility	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5
Violent outburst	Current / Past	1 2 3 4 5
Sexual impulsivity	Current / Past	1 2 3 4 5
Financial impulsivity	Current / Past	1 2 3 4 5
Mood swings	Current / Past	1 2 3 4 5

Please list any additional information you think it is important for us to know about this child/adolescent:

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your time and effort in completing these forms prior to your intake. This form is intended to help your clinician become better acquainted with you and in turn, serve you better. This will also allow us to use our time more efficiently during the intake session.

Good Faith Estimate for Health Care Services

Client			
Client Full Name:		Date of Birth:___/___/_____	
Street or PO Box:			
City	State	Zip Code	
Phone			
Primary Diagnosis (if applicable) ___TBD_____ Diagnosis code: _____TBD_____			
Secondary Diagnosis (if applicable) __TBD _____ Diagnosis code: ____TBD _			
Date(s) of Service	Description	Service Code	Estimated amount to be billed
__/ __ /20__	Diagnostic Evaluation	90791	165.00
__/ __ /20__	Individual Psychotherapy for 50 minutes in an outpatient setting	90834	165.00
Total estimate of what you may owe			
Provider signature: *Ashley Hoffman*		Date: January 1, 2022	
NPI (if applicable) 1699022277		EIN: 46-4074138	

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Patients may determine frequency and duration in scheduling appointments (as needed) during this time period. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the above client. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs or items that may arise during treatment. You could be charged more if complications or special circumstances occur. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. The initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services furnished. To learn more and get a form to start the process or for questions or more information about your right to a Good Faith Estimate, go to www.cms.gov/nosurprises. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above.

_____ _____

Client Printed/Typed Name **Client or Guardian's Signature**

Date _____

AGREEMENT AND INFORMED CONSENT FOR TELEHEALTH SERVICES

Please be advised that I use a secure, HIPAA-compliant video conference software program in order to protect your confidentiality that can be accessed at **www.doxy.me/drashleyhoffman**

There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.

Be informed that even secure transmission of information online is potentially vulnerable to interception by unauthorized parties.

Please be aware that it is your responsibility to take steps to preserve your privacy by using a non shared computer for teletherapy sessions, using a strong password for your accounts, and connecting via a secure network. If you have concerns about the confidentiality of teletherapy participation, please discuss them with me.

Confidentiality still applies for telehealth services, and neither party will record the session without permission from the others person(s).

We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.

You need to use a webcam or smartphone during the session. We must be able to see and hear one another.

It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

It is important to use a secure internet connection rather than public/free Wi-Fi whenever possible.

We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

We will discuss a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

You should confirm with your insurance company that the video sessions will be reimbursed. You are responsible for full payment at the time of services.

I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person as soon as that is available.

By signing below I acknowledge the following:

I have read and agree to the above Agreement and Informed Consent for Telehealth Services

I consent to use secure video conference software for teletherapy sessions. I am aware of the risks of using even secure means of video communication to transmit my protected health information.

I also consent for my emergency contact or the local crisis line to be contacted if my provider feels that I am in a real or potential crisis that could affect the health or safety of myself or others.

I understand that this "Informed Consent for Telehealth" is in addition to the "Informed Consent for Services" which I have already reviewed and signed in the office.

Patient Name:_____ _____ Date:_____