Ashley Hoffman, Psy.D
Licensed Clinical Psychologist
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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. Records will be kept for at least 7 years after termination of treatment. 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. Dr. Hoffman 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.

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:

1. 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.

2. 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.

3. 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.

4. 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:

1. 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.

2. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

4. 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.

1. 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.

2. 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.

3. 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.

The clinicians at Valley Christian Counseling are independently licensed and certified in their respective specialty areas. Each practitioner operates as the sole proprietor of their 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.

_____ _____

Client or Legal Guardian's signature Date

Client Contact Information

Client's Name_____ Date _____
Client Age_____ Sex_____ Ethnicity _____ Date of Birth _____
Home Address _____
City_____ State _____Zip Code_____
Email _____ Cell Phone _____
Home Phone _____ Work Phone _____ (Circle preferred contact #)
*OK to leave a voicemail at preferred contact # regarding appointments? Y N
How did you hear about us:_____
Other family members seen here:_____
In case of an emergency please contact:_____
Relationship:_____ Telephone: _____

Background Information

Reason for Seeking Treatment:_____
_____
_____
Approximately how long have you had the current problem or concern? _____
How was the decision made to come in now? _____
_____
In what ways have you attempted to cope with this problem or concern? _____
_____
What do you hope to accomplish through psychotherapy? _____
_____
Are you currently receiving psychiatric services, counseling or therapy elsewhere? Y N
Have you ever seen a therapist, counselor, psychologist, or psychiatrist prior to this? Y N
*If yes, please list names of providers, dates, reasons for treatment and outcomes of treatment:
_____
_____
_____
_____
_____
Have you ever been hospitalized for psychological problems? Y N
Have you ever received psychological testing in the past? Y N
*If yes, by whom, when, where and for what reason?
_____
_____
_____
Have you ever heard unusual noises or voices that other people nearby were not able to hear? Y N
Have you ever had visions of people or things that seemed real? Y N
Have you ever smelled odors that others nearby did not smell? Y N
Have you thought that someone else might be controlling your mind or putting thoughts into your head? Y N
Have you personally experienced any abuse: ( ) None ( ) Emotional ( ) Physical ( ) Sexual
Do you currently have thoughts of harming yourself? Y N
Do you currently have thoughts of wishing you were dead? Y N
Do you currently have urges to hurt, harm, or kill someone else? Y N If yes, whom? _____
Have you ever attempted suicide or intentionally harmed yourself? Y N

Have you ever seriously considered suicide or felt like harming someone else? Y N
If yes, please explain: _____
_____
Have you lost or gained an unusual amount of weight lately Y N Lost or Gained ____ lbs

Family History

Marital Status_____ Spouse/ Partner's Name_____
How long have you been married? _____ Previous marriages? _____
Is the marriage in trouble? Y N Areas of concern: _____
Do you have any problems with relatives or in-laws? Y N
Are there any issues about your marriage you wish to discuss? _____
Is your spouse willing to participate in psychotherapy? _____
If never married, are you now involved in a serious relationship with anyone? _____
Are you now living alone or with somebody who is not your spouse? Y N
Names and ages of any children: _____

Where were you born/raised? _____
In general, how happy or adjusted were you growing up? ( ) Poor ( ) Average ( ) Completely
Were you ever raised by someone other than your biological parents? Who: _____
Did you have an unhappy childhood? Y N
Were you ever abused or mistreated as a child or teenager? Y N
Were you often in poor health as a child or teenager? Y N
Were you very poor when growing up? Y N
Did you have a poor relationship with your mother or father? Y N
Choose three words to describe your father: _____
Choose three words to describe your mother: _____
What important expectations were held for children growing up in your family of origin?
_____
Were you especially close to any adults other than your parents? Who _____
How was affection expressed in the home where you grew up? _____
How was anger expressed in the home where you grew up? _____
Were there any unusual or disturbing experiences in your childhood? Y N
Do you feel your current problems may be directly related to the way you were raised? Y N
At what age ( ) and under what circumstances did you leave home? _____

How much is your immediate family a source of emotional support for you?
( ) None ( ) Little ( ) Somewhat ( ) Substantial ( ) Always
Who in your family do you currently feel closest to? _____
Most distant from? _____ In most conflict with? _____
Do you have inadequate social support (family/friends)? Y N

Religious affiliation: _____ Place of worship:_____
Was religion a major part of your upbringing Y N
Is religion a major part of your life now? Y N
Would you like your therapist to pray with you? Y N

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 Patient
Autism Spectrum	Y	N	_____
Suicide	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	_____

Education Information and Work History

Highest education level completed: _____ History of learning problems Y N
Were you generally a below average student?____Were you generally an above average student?_____
Were you a behavior problem in school or when growing up? Y N
Were you ever in trouble with the law or juvenile authorities while growing up? Y N

Employment status (Check all that apply):
( ) Employed ( ) Homemaker ( ) Retired ( ) Disabled ( ) Student ( ) Unemployed
If/When employed, what type of work do you do? _____
Current Employer: _____ Years on Current Job: _____
Are you unsatisfied with your present work? Y N

Previous Jobs Held	*How Long*	*Why Left*
_____	_____	_____
_____	_____	_____

Have you been in trouble with the law as an adult? Y N
History of Military Service: Y N Currently in military? Y N Branch: _____
If you served in combat, when did you serve? _____
Type of discharge: _____ Reason for discharge: _____

What are your ambitions in life? _____
Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently: _____
_____

Medical History

Your present state of health is: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Describe any current medical problems (including allergies, asthma, injuries, etc.)
_____
_____
_____
Name of medical provider by whom you were last seen:_____Date_____

Address:_____Phone # _____
How many times a week do you exercise?_____ For how long? _____
Please describe all past major hospitalizations or illnesses (i.e. when, where, how long, for what problem, type of treatment received):
_____
_____
_____

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	Helpful? Yes/No Side effects?

What is your sexual orientation? _____

Are you currently sexually active?	Y	N
Is sex a problem area for you?	Y	N
Is your present sex life satisfactory to you?	Y	N
Has your sexual interest/behavior changed recently?	Y	N
Have you had any unusual or disturbing sexual experiences?	Y	N
Would you like to discuss sexual matters with your therapist?	Y	N

Substance Use History

Have you used any of the following?

	Current Use	Past Use	How much/often	Last time used?
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Cocaine, including crack	_____	_____	_____	_____
Amphetamines, speed	_____	_____	_____	_____
Tranquilizers or sedatives	_____	_____	_____	_____
Caffeine (coffee, tea, cola)	_____	_____	_____	_____
Nicotine (cigarettes, tobacco	_____	_____	_____	_____
Appetite suppressants/diet pills	_____	_____	_____	_____
Hallucinogens, LSD	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Opium/heroine	_____	_____	_____	_____
Medication abuse	_____	_____	_____	_____
Other medication abuse	_____	_____	_____	_____

Have you ever been hospitalized or received treatment for substance abuse problems? Y N
Have you ever tried to cut down on the amount of alcohol you consume? Y N
Has anyone close to you ever been annoyed by your drinking or drug usage? Y N
Do you consider your alcohol consumption or drug usage to be a problem? Y N
In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____
If substance abuse has occurred, please provide specific information including amounts of the substance, withdrawal symptoms, successful, and unsuccessful attempts to decrease or discontinue use.

_____
_____
_____

Personal Perception Circle any words which apply to you according to you:

Competent	Confident	Shy	Unloved
"A nobody"	Not Confident	Weak	Loving
Intelligent	Guilty	Strong	Kind
Stupid	Evil	Superstitious	Considerate
Attractive	Morally wrong	Outgoing	Quiet
Unattractive	Irritable	Friendly	Loud
Plain	Angry	Neat	Bored
Ugly	Aggressive	Messy	Restless
Repulsive	Timid	Disorganized	Regretful
A loner	Misunderstood	Confused	Others: _____
Nervous	Jumpy	Lonely	_____

Please complete the following sentences:

I am a person who_____
All my life_____
I am proud of _____
I regret_____
It's hard to admit that_____
I can't forgive_____
Life is_____
Mother_____
Father_____
I would like to change_____
My earliest memory is_____
My motto is_____
I like_____
My greatest fear_____
What makes me angry is_____
I can't _____
I am embarrassed_____
I secretly_____

Pre-treatment Checklist of Concerns

Please mark all of the items that apply, and add any others at the bottom.

- o I have no problems
- o Abortion, crises/ unexpected pregnancies, post-abortion issues
- o Academic Problems, Learning Disabilities
- o Adoption, infertility
- o Abuse: physical, sexual, emotional, neglect (of children or elderly), animal cruelty
- o Aggression, violence
- o Alcohol use
- o Anger
- o Anxiety, nervousness
- o Attention, concentration, distractibility
- o Autism Spectrum Disorder, developmental concerns
- o Bedwetting
- o Career concerns, goals, and choices
- o Child leaving home
- o Childhood issues (your own childhood)
- o Children, child management, childcare, parenting, child-parent relationships
- o Chronic illness
- o Codependence
- o Confusion
- o Compulsions
- o Crying spells
- o Custody of children, divorce litigation
- o Debilitating injuries/disabilities
- o Decision-making, indecision, mixed feelings, putting off decisions
- o Delusions (false ideas)
- o Dependence
- o Depression, low mood, sadness, crying
- o Divorce, separation
- o Dizziness
- o Drug use – prescription medications, over-the-counter medications, street drugs
- o Eating problems – over-eating, under-eating, changes in appetite, vomiting
- o Emptiness
- o Eviction/repossession
- o Failure
- o Fainting spells
- o Family concerns
- o Fatigue, low energy, constantly tired
- o Fears of specific things, phobias
- o Fear of losing my mind, going crazy
- o Financial or money troubles, debt, impulsive spending
- o Flashbacks
- o Friendships
- o Gambling
- o Gender identity problems
- o Grieving, mourning, deaths, losses, bereavement
- o Guilt
- o Hallucinations, psychosis ***(hearing or seeing things that others don't)***
- o Health, illness, medical concerns, physical problems
- o Heart racing
- o Home life concerns
- o Homicidal thoughts (current or history of)
- o Identity (self-esteem, goals)
- o Inferiority feelings
- o Impulsiveness, loss of self-control
- o Irresponsibility
- o Irritability
- o Job related stress
- o Judgment problems, risk-taking
- o Learned about a "family secret"
- o Legal matters, charges, suits
- o Loneliness
- o Mania
- o Marital conflict, distance/coldness, infidelity/affairs, remarriage
- o Medical concerns
- o Memory problems, forgetfulness
- o Menstrual problems, PMS, menopause
- o Mood swings
- o Motivation, laziness
- o Nausea/vomiting
- o Nervousness, tension
- o Obsessions, compulsions (thought or actions that repeat themselves)
- o Others controlling your thoughts
- o Over-sensitivity to rejection
- o Overambitious
- o Panic or anxiety attacks
- o Perfectionism
- o Pessimism
- o Physical complaints, headaches, other pains
- o Pornography, sexual addictions
- o Premarital counseling, engagement

- Procrastination, work inhibitions, laziness
- Rebellion, oppositional behaviors
- Recent trauma (assault, burglary, accident, etc.)
- Relationship problems, difficulty making friends
- Retirement
- Seeing strange visions
- Self-centeredness
- Self-harm, cutting, burning
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences
- Shyness, over-sensitivity to criticism
- Significant property damage
- Sleep problems - too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spirituality, religious issues
- Stealing
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts (current or history of)
- Temper problems, outbursts, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Tics, motor or verbal
- Trust issues, mistrust of others, suspiciousness
- Uncontrolled behavior/feelings
- Unemployment
- Vandalism
- Verbal abuse
- Weight and diet issues
- Withdrawal, isolating
- Worries, excessive

Please indicate if the following symptoms are either a current or past problem. Please indicate the frequency using the following scale: Never (1); Sometimes (3); Almost Always (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

In the last four weeks have you had an panic/anxiety attack? (Suddenly feeling fear or panic) Y N
*If yes, has this ever happened before? Y N
Do these attacks bother you a lot or are you worried about having another attack? Y N
Do some of these attacks come suddenly out of the blue, or in situations where you don't expect to be nervous or uncomfortable? Y N

<u>Think about your last bad anxiety attack:</u>
Were you short of breath? Y N
Did your heart race, pound, or skip? Y N
Did you have chest pain or pressure? Y N
Did you sweat? Y N
Did you feel as if you were choking? Y N
Did you have hot flashes or chills? Y N
Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? Y N

Did you feel dizzy, unsteady, or faint? Y N
Did you tremble or shake? Y N
Were you afraid you were dying? Y N

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

Other information you feel is important and wasn't asked about: _____

_____

_____

_____

_____

_____

_____

_____

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. You may omit any item, but try to be as thorough as possible. This will allow us to use our time more efficiently during the intake session.

Ashley Hoffman, Psy.D., License # 1860
Licensed Psychologist
5151 Research Dr. NW Suite B1 Huntsville, AL 35805

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:_____