NeuroFaith, LLC

Jeffrey E. Hansen, Ph.D.

Name: ____________________________ **Age:** ___ **Date of Birth:** ______________

Presenting concern(s):

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If patient is a minor, parent name(s):

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Previous Therapies:

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Billing Address:

Name: ______________________________
Street: ______________________________
City: ____________ **State:** **Zip:** ____________

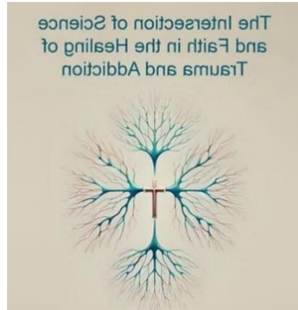
Contact Information (if patient is minor, parent contact information):

Home Phone: _______________________
Work Phone: _______________________
Cellphone: _______________________

Referred by: __________________ **Primary care provider:** __________________

Office use:

Date of service: ________________ DX Code (s): ________________ Fee: _______
Payment: Check: ________ Check Number: _______ Credit Card: ________ Cash: _________ Venmo:________
CPT Code: 90791 90837 90834 90832 90847 90846 Bill insurance: Yes: ____ No: ____



Office Policy and Privacy Practices

This statement explains my fees, services, procedures, therapeutic approach, your rights as a patient, and outlines my education, training, and experience. Your questions are very important to me, so please ask for clarification or further information if needed.

EDUCATION, TRAINING, AND EXPERIENCE: I have a B.A. in psychology from the University of California at Berkeley, an M.A. in psychology from the University of Arkansas, and a Ph.D. in clinical psychology from the University of Arkansas (approved by the American Psychological Association). I completed an American Psychological Association-approved internship at Silas B. Hayes Army Community Hospital in Fort Ord, California, and a post-doctoral fellowship in Pediatric Psychology at Madigan Army Medical Center in Tacoma, Washington. I have worked in a variety of settings to include hospitals, outpatient adult and child mental health, multidisciplinary developmental pediatric clinics, inpatient pediatric wards, an adolescent halfway house, and juvenile courts. I am licensed in Psychology in the States of Washington (PY 1695) and Arizona (PSY-00545).

My practice primarily includes child and adolescent therapy; however, I also offer family and marital therapy when called for in a particular case.

If you desire additional information about my professional experience and training, a copy of my resume is available upon request.

THERAPEUTIC APPROACH: My training experiences have prepared me to work with children, adolescents, and adults in a variety of ways and I will endeavor to explain to you the kinds of treatments that are typically used, approaches to assessment, and length and course of treatment for the issues or problems discussed. I believe that we are best helped when we are treated with dignity and respect and as equal collaborators in our health. We all share in the human experience a certain amount of pain and when we can unload those burdens in safety within a framework based on sound neuroscience, we are able to achieve amazing healing, peace, and fulfillment. My therapeutic approach is always developing based on the most recent science-based research to include, but not limited to, Polyvagal Theory, HeartMath, Acceptance and Commitment Therapy, Internal Family Systems, Positive Psychology, and Cognitive Behavioral Therapy. I encourage you to raise questions about the nature and course of treatment.

CONFIDENTIALITY: The laws of the State of Washington and Arizona require that most issues

discussed with a psychologist remain strictly confidential unless you waive that privilege of confidentiality by signing a "Release of Confidential Information" form. In addition, these laws require the release of confidential information if: (1) you are physically abusing a child (2) suspected of sexual child abuse, (3) planning to harm someone else, (4) you are HIV positive and you are recklessly behaving in ways that could spread HIV, (5) you are going to commit a felony, or (5) you are a danger to yourself, to others, or are unable to meet your basic need for survival. In these cases, I am required by state law to inform the appropriate authorities. Courts may subpoena records and judges may issue court orders requiring disclosure of records and information in court.

I may provide you with appointment reminders (such as voicemail messages, texts, emails, or letters).If you have been referred by another therapist or physician, I will release feedback information to that referral source unless you ask me not to do so. In addition, I will release information to your insurance company as required by that company for billing and managed care purposes unless you ask me not to do so. Please understand that many managed care companies may require detailed treatment reports in order to authorize sessions.

APPOINTMENTS: Individual appointments are usually 50 minutes. I typically spend 10 minutes writing notes and reviewing information at the end of our appointment. In order to maximize the effectiveness of therapy, it is important to be on time as your appointment cannot be extended beyond the scheduled time, since this takes away from other clients' reserved time.

Your appointment time is held exclusively for you. If you are unable to keep your appointment for any reason, please give at least 48-hour advance notice (this excludes weekends and holidays) to cancel; otherwise, you will be charged a $90 no show fee which cannot be billed to your insurance. Similarly, if I fail to give you a 48-hour notice because I cannot keep an appointment, your next session will be discounted $90.

RECORDS: I will keep a record of the health care services I provide you for at least ten years, or if a minor, until age 21 – whichever is more. You may ask to see and copy that record. You may ask me to correct that record. I will not disclose your record to others unless you direct me to do so, or unless there is a legal requirement that compels me to do so.

FEES: Patients and their legal guardians are responsible for their accounts and are expected to pay their bill at the time of service whether medical insurance pays for a portion or not. This includes charges for evaluations, printed materials, reports, letters, consultations, and telephone calls. Payment must be made at the time of the session. When appropriate, I will be happy to assist in the completion of insurance forms which your insurance carrier may require.

My fees for service are as follows:

$220 for the intake appointment (first session)
$180 for each 50-minute psychotherapy or consultation hour
$ 90 for each half hour session
$360 for each hour of legal work
$ 25 surcharge for after-hour emergencies, to include time for emergency phone consultation.

Fees for reports, letters, review of materials, and phone calls may be charged on a pro-rata basis according to time actually required. Fees for reports or letters and certain types of assessments are usually not covered

by insurance carriers.

Unpaid bills will be surcharged at 12% of the unpaid balance on a per annum basis. Bills for which no payment has been made for sixty (60) days will be considered delinquent and will be instituted for collection. The fact of your doctor-patient relationship and content of therapy may be released to appropriate persons for billing insurance and collection of overdue accounts.

EMERGENCIES: In the event of an emergency, you are advised to consider the following options:

- Call 911
- Call the Crisis Clinic at 360.586.2800
- Call the National Suicide Prevention Lifeline at 800.273.8255
- Present directly to your local emergency room

GUARANTEES AND PROMISES: When you request treatment or an evaluation for yourself or for a person for whom you are responsible, be assured that I shall do my best to perform all services in a professionally competent manner and to treat you and your child with dignity and respect.

I cannot guarantee that the results of my evaluation or therapy will conform to your every expectation, and I make no promises to determine any particular diagnosis or to reach any particular conclusion from an evaluation. Effective psychotherapy can at times be confusing and emotionally painful. Effective treatment and accurate assessment depend to a significant degree on your openness, your commitment to change, and our mutual collaboration. You may, at any point, discontinue services with me, request a change of therapy, or request a referral to another therapist. My licensure in the States of Washington and Arizona ensure some attention to competence and provides a complaint/discipline recourse and procedure. For Washington patients, you may address concerns which we are unable to resolve to the Examining Board of Psychology, 1300 Quince Street, Olympia, WA 98504 -7868 (360.753.2147). For Arizona patients, you may submit any supporting documentation with the complaint. The Arizona Board accepts complaints by mail, via fax to 602-542-8279, or by email to: jennifer.michaelsen@psychboard.az.gov

Disclaimer: Although in-person therapy is conducted in an office located in Holdfast Recovery, my private practice is in no way affiliated with Holdfast Recovery. Client agrees to hold Holdfast Recovery harmless for any negative outcomes of therapy conducted by Dr. Jeffrey E. Hansen, Ph.D.

Agreement to Disclosure Statement Terms, Consent to Psychological Services and Agreement to Accept Limits Provider Responsibility:

I acknowledge that I have received a copy of the Statement of Office Policy and Privacy Practices for the office of Jeffrey E. Hansen, Ph.D., Director of NeuroFaith, LLC. This statement describes the types of uses and disclosures of my protected health information (or that of my child) that might occur in my treatment, payment for services, or in the performance of this office's health care operations. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information. I understand the terms of the evaluation and/or therapy process and agree to participate as it is described and to be responsible for fees incurred unless other arrangement have been made. Although the place of in-person therapy is in a Holdfast Recovery office, I agree to hold Holdfast Recovery harmless for any potential negative outcomes of therapy as conducted by Jeffrey E. Hansen, Ph.D.

The Statement of Office Policy and Privacy Practices is also posted in this office and copies are available upon request. The Office of Jeffrey E. Hansen, Ph.D. reserves the right to change the privacy practices that are described in this statement. If office policy or privacy practices change, I will be offered a copy of the revised Statement of Office Policy and Privacy Practices at the time of my first visit after the revisions become effective.

A photocopy or facsimile of this form and signature(s) will be considered as valid as the original.

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Signature of patient/parent/guardian Date

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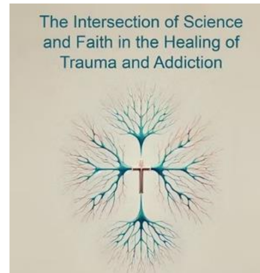
Signature of minor if appropriate Date

Good Faith Estimate (GFE)

NeuroFaith, LLC

Jeffrey E. Hansen, Ph.D.



Brief explanation of estimate for new patients:
The estimate below is the range of costs that is likely for most new patients. Until the initial evaluation is complete to include your identification of specific treatment goals and priorities and we work together to develop the specific treatment plan that you are required to approve - usually within the first three sessions - we will not have sufficient understanding of specific diagnosis, issues, and needs. We conduct a comprehensive diagnostic evaluation of psychological and psychosocial conditions prior to commencement of the treatment or prior to conducting psychological evaluation and test administration and scoring services. This evaluation informs diagnosis and treatment planning discussions which involve your identification of treatment goals and priorities and approval of your treatment plan.

Once you and your provider agree to the treatment plan, patients typically attend 10 - 40 weekly sessions. However, it is common for those patients who are experiencing more complex and/or long-standing issues to require additional treatment sessions during the time covered by this estimate. In addition, at any time during treatment patients may identity additional goals based on their progress in therapy or new/emerging issues. In the event a patient identifies any additional goal(s), a new evaluation may be performed at additional cost and the treatment plan will be revised and approved by the patient and the Good Faith Estimate will be revised and provided to the patient. At any time, the patient or their parent/guardian may choose to stop treatment as described in the Informed Consent.

Details of the Estimate
The following is a detailed list of expected charges for psychological services scheduled for the period of 52 weeks from the date of treatment onset. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless [I/we] send you an updated Estimate.

Integrated Bio/Psycho/Social Assessment (CPT Code 90791) Unit Cost: $200
Unit Cost $200
Estimated number: 1

Individual Therapy (CPT Code 90837):

Unit Cost $160
Estimated number of sessions: 10 - 40
Expected costs: $1600 - $6,400

Total estimated cost: $1,800 – $6,600

Psychologist providing services:
Name/Credentials: Jeffrey E. Hansen, Ph.D.
NPI Number: 1922151547

NeuroFaith , LLC
1579 West Gurley St
Prescott, AZ 86305

This GFE is not a contract. It does not obligate you to accept the services listed above.
Disclaimer
This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to us when we prepared the estimate.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for $400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill.
You may contact the practice at the contact listed above to let them know the billed charges are at least $400 higher than the GFE. You can ask them to update the bill to match the GFE, 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 GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to: www.cms.gov/nosurprises or call CMS at 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

I, the undersigned, acknowledge receipt of Dr. Jeffrey E. Hansen's Goof Faith Estimate.

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Patient/Parent/Guardian signature **Date**