Center for Connected Living, LLC

Jeffrey E. Hansen, Ph.D.

Name: _____ Age: ___ Date of Birth: _____

Presenting concern(s):

_____

_____

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

_____

_____

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: _____

Do you want notes to be shared with referral source or anyone else? If so, please complete the following Release of Information.

Yes ___ No ___

Insurance Information:

Primary Insurance: _____

Name of Insured: _____

ID number: _____

Insurance Address: _____

_____

Office use:

Date of service: _____ DX Code (s): _____ Fee: _____

Payment: Check: _____ Check Number: _____ Credit Card: _____ Cash: _____

CPT Code: 90791 90837 90834 90832 90847 90846 Bill insurance: Yes: ____ No: ____

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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 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 State of Washington (#1695).

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 and adolescents 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. My therapeutic approach is typically behavioral, cognitive, and/or systems-oriented and my therapy is typically more short-term (i.e., ten sessions or less); however, when appropriate, I will contract for long-term psychotherapy. I encourage you to raise questions about the nature and course of treatment.

CONFIDENTIALITY: The laws of the State of Washington 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, postcards, 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:

$200 for the intake appointment (first session)
$160 for each 50-minute psychotherapy or consultation hour
$ 90 for each half hour session
$320 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 to 911
- Call the Crisis Clinic at 360.586.2800
- Call the National Suicide Prevention Lifeline at 800.273.8255

- Present directly to the emergency room at St. Peter Hospital (360.493.7289)

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 State of Washington ensures some attention to competence and provides a complaint/discipline recourse and procedure. 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)

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 the Center for Connected Living. 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.

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.

_____

Signature of patient/parent/guardian Date

_____

Signature of minor if appropriate Date

Revised 12 September 2021

Center for Connected Living, LLC

Jeffrey E. Hansen, Ph.D.

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize Dr. Jeffrey E. Hansen to use, disclose, obtain my health information during the term of this Authorization to/from the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released/obtained to/from the following recipient(s):

Name: _____
Address: _____
_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Only the following records or types of health information:

_____

Term: I understand that this Authorization will remain in effect for:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____ _____
Signature of patient/parent /guardian Date