Gary J. Neuger, Ph.D.
4801 Lang Ave. NE, Suite 110
Albuquerque, NM 87109
(505) 798-2552 Fax (505) 796-9601
www.intelligenthypnotherapy.com

General Instructions for New Patients of Dr. Neuger

(Please read and follow these instructions. You are encouraged to keep this page for future reference.)

1. You will need to complete the following pages 1 through 6 and return them to Dr. Neuger before an appointment can be scheduled. Additionally, Dr. Neuger's HIPAA paperwork is available on his web site. Please read the HIPAA documents carefully, and then sign and date the signature page of the "Psychotherapist-Patient Services Agreement" which can be found at Page 4 of this paperwork (below). If you do not fully complete the paperwork, Dr. Neuger will take time out of your first appointment to ask you for the information. That is time better spent helping you. Please take your time and be thorough. Complete the Telemental Health Informed Consent even if you plan to treat in-person.

2. Once we receive your paperwork we will contact you to set up your first appointment. You can scan and email the paperwork (gneuger@aol.com), fax it back, mail it back, or drop it off in person. **If you fax or email it back to us, please then bring all of the originals with you to your first appointment.**

3. Arrive for all of your appointments ***on time***.

4. Dr. Neuger's office is in the Plaza Paseo building. This is a 2-story office building on the North side of Lang Ave. NE off of Jefferson Ave. (see picture below)

5. Free parking is provided in the parking lot on the South side of the building. Entering from the South entrance, Suite 110 is immediately to your right.

6. Check in with the receptionists and they will let Dr. Neuger know you have arrived.

7. Follow-up appointments are scheduled with Dr. Neuger at the end of your sessions or by calling the office number and scheduling with the receptionists. Payments for services rendered are made directly to Dr. Neuger via cash, check, or credit card. Payment of your portion of the bill is due at the time of service unless other arrangements have been made ahead of time with Dr. Neuger himself.

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INSURANCE *(Print legibly and* provide All information requested)

Patient Name:_____ DOB:_____/_____/_____ Today's Date: _____/_____/_____

How will you be paying for services rendered by Dr. Neuger? (circle one) Self pay (If self pay, skip to page 2) Insurance (complete rest of form)

INSURANCE INFORMATION: Dr. Neuger is happy to bill insurance on behalf of his patients. He cannot tell you what coverage your insurance company will provide. ***It is your responsibility to know your insurance coverage.*** Many patients find this form helpful in determining what their mental health insurance benefits actually are. Dr. Neuger asks for your assistance in billing correctly by giving him complete and accurate information. **Please complete this entire form.** It is imperative you **CALL YOUR INSURANCE COMPANY** to answer the questions below. The information on your insurance card usually does not apply to your mental health benefits. Thank you for your time and efforts in obtaining correct information. **Complete a separate form for each carrier.**

Insurance Company:_____ Subscriber #: _____ Group #:_____

Billing address for claims:_____

Claims phone #: (_____) _____

Name of Insured:_____ Date of Birth:_____/_____/_____ Employer:_____

Ins. Co's Member Services phone #: (_____) _____ Mental Health Phone #, if different: (_____) _____

Name of benefits person spoken with (**very important!**):_____

Is Gary J. Neuger, Ph.D./ Intelligent Hypnotherapy (NPI: 1396237848) a member of my network? Yes No
Is prior authorization required for mental health services? Yes No

If yes, please authorize an initial visit (CPT code 90791) and follow up visits (CPT code 90837) with Dr. Neuger for a one-year period.

_____	_____	_____
Authorization Number	Dates Valid	Number of Sessions and CPT Codes Authorized
_____	_____	_____
Authorization Number	Dates Valid	Number of Sessions and CPT Codes Authorized

What is the effective date of my insurance coverage? _____ Is my plan an: HMO PPO Other (specify)_____

What is the renewal calendar date or specific contract date?_____

What is my individual deductible? $_____ How much has been met to date? $_____

What is my mental health co-pay or percent not covered by insurance (this will be your responsibility to pay at time of service)?

$_____ or _____%
Co-Pay $ amount Percent amount

If limited, how many mental health visits am I allowed per year?_____ How many remain for this year?_____

Do I have any annual or lifetime maximum coverage limit for mental health? _____

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Print legibly ***and*** **provide all information requested. Do not leave any spaces blank. If a section does not apply, write "NA."**

CLIENT INFORMATION

Today's Date:_____

Client's Name: _____ Birth date:_____ Race:_____

Age:____ Sex:_____ Marital Status (circle): S M Sep Div Wid Email:_____

Social Security #:_____ Education Completed:_____

Address:_____

_____ Zip _____

Telephone: (Home)_____ (Work)_____ (Cell)_____

Occupation: _____

Employer:_____ _____
Name Address

Spouse (parent, if patient is a child):

_____ _____ _____ _____ _____
Name Age Years Married Education Completed Occupation

Closest blood relative not living in your home: Name: _____

Address:_____ Phone:_____

Who referred you to this office?_____

May Dr. Neuger contact this person? If so, please sign and date:

_____ _____
Signature Date:

If you are self-referred, how did you find Dr. Neuger (check all that apply):

Psychology Today ____
www.intelligenthypnotherapy.com ____
Other (please identify):_____

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OFFICE POLICY and FEE AGREEMENT

This form MUST be signed before services can be provided. Please read carefully before signing.

CONFIDENTIALITY The confidentiality of psychological records is protected by New Mexico State law, and is explained in Dr. Neuger's "Psychotherapist-Patient Services Agreement," and "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information." Please read these documents carefully, sign and date the signature page of the "Psychotherapist-Patient Services Agreement" and include the signature page with this paperwork.

CANCELLATIONS AND MISSED APPOINTMENTS (***If you do not understand any portion of this, please clarify with Dr. Neuger before signing.***) Notice of at least 48 business hours is required to cancel an appointment. This means that if you "no-show," or cancel an appointment within 48 business hours of the scheduled time, you will be billed for the appointment. Exceptions will be made only in the event of severe illness, a true emergency, or dangerous driving conditions due to severe weather. ***Lack of transportation for any reason and scheduling conflicts with work or other activities do not constitute an emergency.*** A scheduled appointment is time reserved specifically for you with Dr. Neuger. Advanced notice of cancellation is required to be able to offer the appointment time to someone else. If you do not keep your appointment, it cannot be charged to insurance, and you will be held responsible for payment of the full fee. Assume that a cancellation within 48 hours ***will*** be charged to you unless otherwise stated to you by Dr. Neuger.

FEES and INSURANCE Payment in full is expected at the time of service, unless other arrangements have been made with Dr. Neuger, or expressly prohibited by your insurance. Dr. Neuger's fee is $325 for the first one-hour session, and $215 per hour thereafter. A discount of $15 is offered if payment in full ($200) is made **at the time of service**. Payment after the date of service no longer qualifies for this discount. You are responsible for all charges incurred for services rendered, even if health insurance may eventually pay a portion. If you have insurance, you are expected to know your benefits and to pay your deductible and copay when they are due. Cash, check, or credit cards are accepted. Returned checks will be charged triple the amount. A processing fee of 3.5% will be added to all credit card payments.

If payments are not made in a timely fashion, the account will be subject to interest at 1.75% per month and a rebilling fee of $7.00 per month. If it becomes necessary to enlist the services of a collection agency, you will be held responsible for any costs incurred in that process, including attorney's fees, court costs and a collection fee equaling 50 percent of the balance due. If collection action is instituted, your name and the type of services provided (e.g., "counseling") may be disclosed to the extent necessary to enable us to prove any claim for fees and costs not paid. However, further details regarding you and your treatment will not be disclosed when such disclosure would violate the psychologist-client relationship established by the standards of professional conduct governing licensed psychologists, or when disclosure is otherwise prohibited by law.

AFFIRMATION: I have carefully read and fully understand all of the above, am aware of Dr. Neuger's hourly fees and cancellation policy, and agree to the terms stated.

Patient or responsible party	Gary J. Neuger, Ph.D. or agent
Date	Date

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

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

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT IN IT'S ENTIRETY AND AGREE TO ITS TERMS, THAT YOU FULLY UNDERSTAND DR. NEUGER'S CHARGES AND CANCELATION POLICIES, AND ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature of Patient Date

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NSA Notice & Good Faith Estimate Questionnaire

This MUST be completed before I can provide any services to you.
Please reach out before signing if you have any questions.

Are you enrolled in (check all that apply)?

1. Group health plan _____
2. Group or individual health insurance coverage offered by a health insurer _____
3. Federal health care plan _____
4. Health benefits plan under a Federal Employees Health Benefits (FEFB) program ___

If you checked any of the above 1-4:

am I (Gary J Neuger, Ph.D./ Intelligent Hypnotherapy, LLC) in-network or out-of-network with your plan? _____ (Fill in "in" or "out") If "in," skip the next question and sign below;

if you wrote "out" do you intent to submit, or wish me to submit claims for the services I will be providing you to that plan or coverage? _____ (Fill in "yes" or "no")

If you wrote "yes" above or are planning to pay for services out-of-pocket (i.e., self pay), do you wish to receive your Good Faith Estimate on paper or electronically? (check only one of the following)

Paper Copy: in person_____ by mail_____ electronically via email_____

I have received a copy of the NSA Notice via my selected method.

_____ _____
Patient or responsible party Date

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TELEMENTAL HEALTH INFORMED CONSENT

This form MUST be signed before services can be provided online

I understand and agree to receive tele-mental health services (video therapy) from Dr. Neuger. This means that Dr. Neuger and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and Dr. Neuger's Office Policy and Fee Agreement form. I understand that if I arrive late for a session, I may be charged a portion of the fee as this cannot be charged to insurance companies.

I understand the potential risks of video therapy, which may include the following: the video connection may not work, or it may stop working during a session; the video or audio transmission may not be clear, and; I may be asked to attend in-person therapy if it is determined that video therapy is not an appropriate method of treatment for me.

I recognize the benefits of video therapy, which may include the following: reduced cost and time commitment for treatment due to the elimination of travel; ability to receive services near my home or from my home, and; access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that Dr. Neuger uses HIPAA-compliant technology to transmit and receive video and audio, and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws.

I understand that if we have technical issues during a video therapy session, Dr. Neuger will attempt to continue the session by phone using the number I have provided in my intake paperwork.

I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. I further understand that if I sign into a session from a location that is different from my normal one, I will inform Dr. Neuger of this immediately at the start of the session.

I understand that recording my sessions in any manner is prohibited.

I understand that I have the option to request in-person treatment at any time, and Dr. Neuger will assist in scheduling this, or making a referral if travel to his office is not feasible for me. I understand that closer providers may not be available depending on my location.

I understand the limitations to confidentiality with Dr. Neuger include reasonable belief that I am a danger to myself or others. I understand that, if Dr. Neuger reasonably believes that I plan to harm myself or someone else, he will contact local emergency services to come to my location and ensure my safety.

AFFIRMATION: My signature indicates that I agree to participate in video therapy under the conditions described in this document.

Patient or responsible party

Date