

Judith L. Sloan-Price, LCSW
512-922-2256
12741 North Highway 183
Building 300 Suite 301

DIRECTIONS

From 620:

You cannot get here from McNeil Road. Go south on 183 from 620 and take the Oak Knoll exit. Turn around and take the McNeil exit, going north and following the directions below.

Going North on 183:

Overview I am located on the access road from McNeil exit, *before* the blue water tower, just after KNLE radio station with a blue candle in the middle. You'll see a tall sign with Afterschool Daycare Program. This is my parking lot.

Detailed Directions

1. Go north on 183
2. Take the McNeil exit and stay on the access road. **Do Not Go to McNeil!**
3. Go Past:
U-haul, bright red door and yellow door, McNeil Research Office Park, Research Vision Center and the blue sign with a candle in the middle at KNLE-FM station.
You will see a huge sign with the names of After School Daycare Program, Psychotherapy Offices, and other businesses.
4. My office is the next driveway, turn right into Large Oak Plaza. Park in the first lot on the left side. My building is 300, behind the After School Day Care Program.
5. Walk through the lobby into my waiting room, suite 301.

Please complete the following forms and *bring them* with you to our appointment.
Thank you!

RATES

If I am an in-network provider on your insurance panel and your plan covers these services, the following rates will be discounted according to your benefit plan.

Initial Evaluation 60 minutes \$140

Follow Up Sessions are 50 minutes for \$110

\$15 extra for 5pm or after appointments

120 minutes Friday only: \$364 (this is two sixty minute sessions, back to back at \$132/hr + \$100 for Friday appointment. I do this only as time permits.

Court appearances: \$190/hr. with a four hour minimum. Travel time is charged at \$190/hr.

Cash or checks only accepted – sorry, no credit cards at this time

Judith L. Sloan-Price, LCSW
Time Sensitive, Strengths Focused Psychotherapy
12741 N. Hwy 183 Suite 301
Austin, Texas 78759
512-922-2256 512-336-9351 (Fax)

PATIENT INFORMATION SHEET

*Please read, *sign* and return. You may request a copy for your records.

1. Description of Professional Services: Psychotherapy services many include the following: initial evaluation, consultation, individual, Couple, and or Family psychotherapy, and telephone conferences. The goal of psychotherapy is to promote health individual and relational functioning. The aim of the provider of psychotherapy is to use professional training and experience to promote competence and social-emotional adjustment.
2. Appointments: the first appointment is generally an Initial Evaluation which lasts approximately 50-60 minutes. You will be asked to complete forms that provide information about your personal mental and physical health history prior to that meeting. Consultation and Individual Psychotherapy sessions are 50 minutes long. Couples and Family Therapy are generally 50 minutes long and may be attended by some or all family members. Telephone Conferences may be needed between appointments or to coordinate services among professionals.
3. Length of Psychotherapeutic Treatment. Psychotherapy is generally relatively brief (10 sessions or less), but this is not always the case. After an initial evaluation, psychotherapy may or may not be one of the recommendations. If a patient engages in therapy, a treatment plan is devised based upon goals that were collaboratively developed between client(s) and the therapist. Evaluation of treatment goals leads to decisions about shortening or lengthening treatment.
4. Client History. For purposes of therapy, and/or assessment, it is often important to assess current functioning in light of family history. Questions may be asked about individual and family social, medical, psychiatric and psychological history.
5. Confidentiality: Professional ethics and state law require complete confidentiality of information shared as a result of psychotherapy services rendered. Cases will not be discussed with anyone without written consent from adults and/or parents of minor patients, except as follows: 1. If contact reveals that the patient is a danger to self or others. 2. If child abuse, or abuse of an adult with a disability is suspected. 3. To insurers for claims payment. 4. To mental health professionals who are in practice with the provider for purposes of "covering" for the provider when she is unavailable or for purposes of hospitalization or for emergency psychiatric services. 5. As required by state regulations.

6. Cancellation and missed Appointments Policy. Missed appointments or those cancelled with less than 24-hour notice carry a \$50 charge (\$65 for after hour appointments). This fee is payable at the time of the next appointment. ***The patient, not the insurance carrier, is responsible for this charge.*** Repeated absences may be charged at full fee. Courtesy reminders for appointments may or may not be issued by our office. Regardless, client is responsible for remembering their appointments.

7. Payment for Professional Services Rendered. Payment is required at the time of services rendered, unless prior arrangements have been made. Fees are as follows:
Initial Evaluation \$140 Family/Conjoint/Individual \$110 \$15 more for 4:30pm or after appointments
or as contracted with insurance provider by the therapist. Court appearances \$190/hr. with a four hour minimum. Travel time is charged at \$190/hr.

There will be a charge for frequent telephone contacts of longer than 10 minutes. Fees will be charged for letters, copies, and/or reports requested. Records sent to other mental health professionals will be sent free if they can be faxed, up to 20 pages. A flat fee of \$50 will be charged thereafter. All other copies of records will be sent for \$50.

8. Insurance. It is the responsibility of the patient to know their insurance benefits. You will need to determine the types of mental health providers that are covered by your policy, as well as which types of diagnostic categories and psychotherapy services are covered. **It is your responsibility to obtain the initial authorization and to keep track of the number of sessions used in an authorization.** Patients will be responsible for reimbursing the provider if services exceed benefits outlined in their policy or managed care plan, or if their insurance is terminated while in treatment.

9. Overdue Accounts and Insufficient Funds. Accounts are considered delinquent after 30-days of nonpayment. If an account reaches \$100, routine visits will terminate unless payment of the entire amount due is made at the time of service. Delinquent accounts may be turned over to a collection agency, with a surcharge for any applicable collection fees. \$25 will be added to the total due for checks returned due to insufficient funds.

10. Ethical and Professional Standards. The ethical guidelines and practice standards published by the National Association of Social Workers are adhered to in this practice. The Texas State Board of Social Worker Examiners regulates the practice of psychotherapy.

11. Patient Questions. Patients are encouraged to directly address any and all questions about services to the service provider, Judith L. Sloan-Price, LCSW. Questions about consumers' rights may be addressed to the Texas State Board of Social Workers Examiners.

12. Follow-up Services. You may be contacted after termination of services for purposes of quality control and practice development.

My signature attests to the following:

1. I have read this information and I consent to engage in psychotherapy services.
2. I authorize Judith L. Sloan-Price, LCSW to release any pertinent information acquired in the course of my evaluation or treatment to my insurance company.
3. If pertinent, I authorize my insurance benefits to be paid directly to Judith L. Sloan-Price, and I understand I am financially responsible for non-covered services.
4. I understand that Ms. Sloan-Price is a sole practitioner in independent practice and not part of a group practice.

Signed _____ Date: _____

Signed _____ Date: _____

CANCELLATION & MISSED APPOINTMENTS POLICY

(Please sign below)

Clients are expected to notify the therapist 24 hours in advance if they must cancel, *even if it is not the client's fault*. I understand that sometimes you must cancel for reasons beyond your control, e.g. bosses requiring you to work. For that reason, I am willing to absorb some of the cost of your misfortune with you and will *not initially* charge the full fee. Missed appointments or those canceled with less than 24-hour notice carry a charge of \$50 (\$65 for after hour appointments). Repeated late cancellations may result in full fee charges.

This fee is payable by the time of the next appointment, if applicable. The client, *not* the insurance carrier, is responsible for this charge.

Thank you.

Judith L. Sloan-Price, LCSW

I have been notified of the cancellation procedures for this office.

(Signature)

(Date)

PLEASE SIGN BACK SIDE

TEXAS NOTICE FORM

Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal
 - or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to

yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

▪ **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post a revised copy in the office and provide you with a copy upon request.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Social Work Board of Examiners, 512-719-3521. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on April 15, 2003.

I have been given the opportunity to receive a copy of this document as well as read it.

Patient	Date
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ALL NEW CLIENTS MUST COMPLETE AND SIGN #13

INSURANCE WORKSHEET AND/OR WAIVER TO USE INSURANCE BENEFITS

FOR _____
(client) (date)

IF YOU WISH TO USE INSURANCE BENEFITS I must have complete and accurate answers to the following questions by the first appointment.

Please ask for **MENTAL HEALTH** benefits for all questions

1. NAME OF INSURANCE COMPANY PPO ___ HMO ___ EAP ___

2. CLAIMS ADDRESS & PHONE NUMBER FOR **MENTAL HEALTH** CLAIMS?

Please ASK! The information on your card is usually wrong.

3. AM I AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER? IN ___ OUT ___

4. DO YOU NEED PRE-AUTHORIZATION? IF YES:

A. AUTHORIZATION NUMBER _____
B. # OF APPROVED SESSIONS for this authorization _____

5. DEDUCTIBLE? IF YES,
AMOUNT \$ _____
AMOUNT MET THIS SO FAR \$ _____

6. CO-PAY OR CO-INSURANCE AMOUNT \$ _____

7. CALENDAR YEAR BEGINS _____

8. CALENDAR YEAR ROLLOVER YES ___ NO ___
AMOUNT OF ROLL-OVER FOR THIS YEAR \$ _____

9. MAXIMUM NUMBER OF SESSIONS PER YEAR _____

10. CAN YOU BE SEEN MORE THAN ONCE PER WEEK IF NEEDED? _____

11. **COUPLES/MARITAL THERAPY** IS COVERED? YES ___ NO ___
THIS IS NOT THE SAME AS FAMILY THERAPY – PLEASE ASK.

12. OUT-OF-NETWORK BENEFITS:

- A. Do you need pre-certification? If yes, see 1 A&B
- B. What are limits for “reasonable and customary” for an LCSW (social worker) for 90801 and 90806 and 90847? (If you can’t get this easily, don’t worry about it)
- C. Is there a maximum per session that the company will pay? \$ _____

ALL NEW CLIENTS MUST SIGN BELOW

13. Please check any of the following that apply to you and sign:

- ___ I do not wish to use my insurance plan & will cover costs myself
- ___ I understand my insurance plan will not cover these services and I will cover costs myself.
- ___ I understand I will pay the total cost for services to the therapist and be reimbursed from my insurance company after I file my own claims.
- ___ I understand my insurance plan will cover services and I am responsible for any deductibles, co-pays or co-insurance fees as required.

Name of Client Date

P.2 History

MEDICAL **Nothing Applies** ___

MILITARY HISTORY

__liver disease __ kidney disease __pancreatitis
__mononucleosis __epilepsy __ thyroid disease __cancer
__heart trouble __diabetes __venereal disease __AIDS or HIV+

List any other medical problems you have not listed above:

8. Please list any significant **medical problems or mental illnesses** suffered by your parents, children, brothers and sisters, or grandparents, including Alcoholism, Chemical Dependency, Depression, etc.

9. Current Alcohol or illegal drug use (include recreational drugs, e.g. marijuana):

TYPE: _____ **Frequency:**

Last Use: _____ **Amount:**

10. Current tobacco use (**Type, Quantity**) _____ **Caffeine use (Type, Quantity)**

=====

Below is a list of problems and complaints that people sometimes have.

Please select the answer that *best* describes how you have felt *during the past month, including today.*

YOU MAY HAVE TO PRINT OUTSIDE THE MARGINS

Never Rarely Sometimes Frequently Almost

Always

I have trouble sleeping- too much or too little					
I feel no interest in things					
I feel stressed at work, school, home or other daily activities					
I have experienced (circle any applicable):pains in my chest or heart; faintness or dizziness; hot or cold spells; trouble catching my breath; nausea or upset stomach; numbness or weakness in my body; feeling like I am going crazy; mind going blank; heart pounding or racing; scared for no reason					
I feel irritated					
I have urges to beat, injure or harm someone, or smash things					
I feel something is wrong with my mind					
I have frequent arguments					
I am not tired and need less sleep than usual					
My mind has never been sharper					
I have more plans and new ideas than I can handle					
Has there ever been a period of time when you were so happy or excited that you got into trouble, or your family or friends or a doctor said you were manic?					
I talk so fast it's hard for people to keep up with me					
I have been thinking about sex					
I have been spending too much money					
My attention keeps jumping from one idea to another					
I find it hard to slow down and stay in one place					
I have difficulty concentrating					
I feel hopeless about the future					
I have thoughts of ending my life					
I feel worthless					
I use alcohol or a drug to get going in the morning					
Disturbing thoughts come into my mind that I cannot get rid of					
People criticize my drinking or drug use					
I can drink more alcohol than most people before it affects me much.					
I have difficulty making decisions					
I feel guilty					
I am eating more or less than I used to (not due to dieting)					
I have to repeat the same actions, e.g. counting, washing					
I check and double check or must follow unusual routines					

MASTER REGISTRATION INFORMATION

Person responsible for account completes this form please

Referred by: _____ Email: _____

CLIENT: (PERSON BEING SEEN):

LAST NAME	FIRST	MI	NICKNAME	
ADDRESS	STREET	CITY	STATE	ZIP
SOCIAL SECURITY #	DATE OF BIRTH	INSURANCE ID # ON CARD		
EMPLOYER				
PHONES:	HOME	CELL	WORK	

EMERGENCY CONTACT: _____

NAME	ADDRESS	PHONE
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PARENT OF CONTACT PERSON (IF APPLICABLE)

NAME	LAST	FIRST	MI	NICKNAME
ADDRESS	STREET	CITY	STATE	ZIP
PHONE:	HOME	CELL	WORK	

INSURANCE INFORMATION

PRIMARY INSURED PERSON (IF OTHER THAN CLIENT)

NAME	LAST	FIRST	MI	NICKNAME
ADDRESS	STREET	CITY	STATE	ZIP
PHONE:	HOME	CELL	WORK	
EMPLOYER:	INSURANCE ID #	GROUP #		

SOCIAL SECURITY # _____ **MALE / FEMALE** **DATE OF BIRTH:** _____

INSURANCE COMPANY: _____

NAME	PHONE(S)		
MENTAL HEALTH CLAIMS ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE: _____

POLICYHOLDER	COMPANY NAME	PHONE	
SOCIAL SECURITY #	DATE OF BIRTH	PHONE: _____	
LAST	FIRST	MI	MALE / FEMALE