

Judith L. Sloan-Price, LCSW

6904 Fireoak Drive

Austin, Texas 78759

512-922-2256 Phone

512-336-9351 Fax

jsp@jsptherapy.com

www.jsptherapy.com

DIRECTIONS

FROM 620 (GOING SOUTH)

Go south on Hwy 183. Take the Oak Knoll exit and turn right onto Oak Knoll. Go approximately 6-7 blocks and turn right onto Fireoak. *The office is a separate building on my residential property.* There is no signage. The house is at the corner of Fireoak and Bristlecone. **Please park on Bristlecone.** Enter through the second side gate, then an iron gate. Office is in front of you.

GOING NORTH ON 183:

Take the Oak Knoll exit and turn left onto Oak Knoll. Follow the instructions above.

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

RATES

Initial Evaluation 60 minutes \$150

Follow Up Sessions:

**60 minutes - \$130
75 minutes - \$165
90 minutes - \$200
120 minutes - \$265**

\$20 extra for 4:30pm or after appointments

120 minutes minimum on Friday, Saturday or Sunday only: \$365 (includes an additional \$100 convenience fee). I do this as my time permits.

Court appearances: \$200/hr. with a four hour minimum. Travel time is charged at \$200/hr. from leaving my office to arrival at destination.

***Research has shown that 90 minutes sessions are more effective than 60 minute sessions for couples. I have found meeting 90 minutes every other week is more beneficial than 60 minutes every week. Of course, some couples prefer meeting weekly in the beginning, and I can often accommodate that request.**

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

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: _____ **Client's Email:** _____

CLIENT: **Driver's License:** _____

LAST NAME FIRST MI NICKNAME

ADDRESS STREET CITY STATE ZIP

DATE OF BIRTH

PHONES: HOME CELL WORK

EMERGENCY CONTACT: _____
NAME ADDRESS PHONE

PARENT OF CONTACT PERSON (IF APPLICABLE)

NAME _____
LAST FIRST MI NICKNAME

ADDRESS _____
STREET CITY STATE ZIP

PHONE: _____
HOME CELL WORK

Judith L. Sloan-Price, LCSW
Time Sensitive, Strengths Focused Psychotherapy
6904 Fireoak Drive
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 60 minutes. Follow up appointments are at least 60 minutes long, to be decided by the client and therapist. You will be asked to complete forms that provide information about your personal mental and physical health history prior to that meeting. 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 late charge, viewable at www.jspsytherapy.com. This fee is payable at the time of the next appointment. Repeat absences may be charged at full fee. Courtesy reminders for appointments may or may not be issued by our office. Regardless, the 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 posted at www.jspsytherapy.com.

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. I do not take insurance. I will not file forms to insurance companies, but will provide you with a receipt you can submit to your insurance company to receive reimbursement.

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. I understand that Ms. Sloan-Price is a sole practitioner in independent practice and not part of a group practice.

Signed _____ Date: _____

Signed _____ Date: _____

AUTHORIZATION TO USE EMAIL

Email is the fastest way to secure an appointment. I will respond with options typically the same day or within 24 hours. You may also call for an appointment. I typically respond to calls within 2-3 days.

The majority of the time, I send reminders by email. I do this as a courtesy and to avoid error, but occasionally do not have time to send reminders. Clients are still responsible for remembering their appointment whether I sent a reminder email or not. I will not convey reminders by phone.

Texting: Please do not use texting unless it is to tell me you are running late for an appointment. If you do, understand any information conveyed is not protected.

I understand communication by email is not encrypted and therefore any private health information conveyed by email is not protected. Nonetheless, I want to use email to communicate with Judith L. Sloan-Price, LCSW.

Yes _____ No _____

Client signature(s) _____ Date _____

_____ 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 charges as follows:

50 – 60 minute appointments: \$50

75-90 minute appointments: \$100

120 minute appointments: \$125

+\$20 for any appointment scheduled for 4:30 pm and after

Repeated late cancellations may result in full fee charges.

This fee is payable by the time of the next appointment, if applicable.
FYI: Most insurance companies will NOT cover these charges.

Thank you.

Judith L. Sloan-Price, LCSW

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

(Signature)

(Date)

Notice of Privacy Practices (effective January 18, 2013)

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at: Judith L. Sloan-Price, LCSW, 6904 Fireoak Drive, Austin, Tx. 78759

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Judith L. Sloan-Price, LCSW 6904 Fireoak Dr., Austin, Tx 78759 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Counseling File Disclosures and Limitations

1. Unless specified otherwise, the service provided was for counseling only and does NOT include a forensic evaluation (i.e., not an evaluation or assessment for legal reasons). The work reflected in this file was for clinical reasons only and typically involves helping clients achieve their goals which often includes improving or reducing their symptoms. If counseling is for a couple, work is often to improve their relationship or on some occasions to help them transition through the ending of their couple's relationship such as to transition in becoming more effective co-parents after a divorce or separation. Therefore, the purpose is clinical and not forensic. In fact, it would not be prudent to attempt an integration of clinical and forensic roles in working with an individual or couple, because that could establish a dual relationship where the clinical and forensic role could be in conflict with one another.
2. The assessments that may be included in this file are for clinical purposes only. Unless specifically noted otherwise, the assessments that may be included in Ms. Sloan-Price's file for you are NOT intended or valid for forensic purposes. Specifically, all instruments (questionnaires) are self report where a person may respond in any manner whatsoever (based on their perception that mayor may not be accurate, respond according to an individual's personal agenda, may over or under report, etc.). These instruments do NOT include a validity scale that can verify different aspects of the client's responses including possible under or over reporting and consistency of responses, for example.
3. Statements made by a client may be included in progress notes and simply represent their statement, perception, or perhaps their point of view. Just because they are in the note/file does not mean they are "fact" or "true" in any manner. Inclusion in the note may simply mean that the statement was made or observed. Unless specifically stated in the note, these statements have not been verified for accuracy or corroborated in any way.
4. Any interpretations, conceptualizations, or perceptions when included in the note or elsewhere in this file are likely tentative or form a part of the process for working clinically with a client(s). Unless specifically noted otherwise, they are not to be intended and are NOT valid for forensic purposes.
5. When a client seeks counseling services initially for a clinical or relationship concern, information in the file and work with this client mayor may not be applicable to meet a future or other need such as forensic (legal) or disability evaluation. If needed, Ms. Sloan-Price may be able to provide a referral to another provider who may be able to assist in these matters.

Judith L. Sloan-Price, LCSW

I have read and understood this document: _____

_____ Date

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have been given the opportunity to read and receive a copy of Judith Sloan-Price's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Judith L. Sloan-Price, LCSW at 512 922 2256.

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member **Date**