ASHA JANE
THERAPY FOR THRIVING

Asha Jane, MA, LMFTA
Licensed Marriage & Family Therapist Associate
11300 Antler Lane
Austin TX 78726
P: 512.567.6944
E: aj@ashajane.com

Registration Information

Date_______________

Name____
Last First MI Preferred Contact #

____
Home Address City State Zip

____
Employer Occupation Work # Email

____
Social Security # Sex DOB

____
Home tel # Cell phone #

EMERGENCY CONTACT*

____
Name Relationship

____
Street Address City State Zip

____
Cell phone # Work # Home # Other #

***I AGREE THE EMERGENCY CONTACT MAY BE CONTACTED IN THE CASE OF A PERCEIVED EMERGENCY.**
INITIAL __________

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Adult Information Form

1. Please describe your goal in making this appointment.

2. When did the difficulty begin and what motivated you to seek this appointment at this time?

3. What help have you sought for this problem or related problems? Include dates of past therapy.

4. What results did you have?

5. List the age(s) that any of the following occurred in your life:

______childhood fears	______sexual abuse	______incest
______bedwetting	______school phobia	______hyperactivity
______behavior problems	______running away	______teenage pregnancy
______truancy/school refusal	______juvenile delinquency	______drug/alcohol abuse
______physical abuse	______anorexia	______binge eating
______rape	______suicide attempts	______cutting/self-mutilation
______sexual problem	______infidelity	______recent divorce

6. List all current medications or treatments for health problems, including natural remedies and vitamins (use back if necessary).

7. If you are taking medications, list the prescribing physician:

8. Do you use:

Alcohol	___Yes	___No	Frequency of Use______	Amount______
Drugs	___Yes	___No	Frequency of Use______	Amount______
Tobacco	___Yes	___No	Frequency of Use______	Amount______
Caffeine	___Yes	___No	Frequency of Use______	Amount______

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9. Describe any physical problems you are experiencing:

10. What do you do for relaxation, fun, or pleasure?

11. What beliefs do you hold about yourself?

12. How do other people describe you?

13. Describe your current intimate relationship(s):

14. What are your spiritual practices?

15. Please list any past/current medical or psychological problems suffered by your children, siblings, parents, or grandparents (e.g., depression, anxiety, drug/alcohol abuse, suicide, or psychiatric hospitalization).

16. Is there anything else you would like me to know about you?

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Office Information

I appreciate the opportunity to work together with you. My goal is to provide effective and efficient help for the problems you are experiencing. Below is information about my office policies.

My intention is for my office to feel comfortable and safe. Please let me know if there is anything I can do to help you achieve that goal.

Prior to the first visit, please complete the appropriate forms as they provide information for the first meeting. You can send them back or bring them with you on your first visit.

The information you share with me is confidential and will not be discussed with anyone without written consent, except in the following situations: 1) If you share information that indicates that you are a danger to yourself or others; 2) If abuse of a minor, elderly, or disabled person is suspected, or if you provide information about such abuse; 3) To insurers for claims payment; 4) To mental health professionals who are in association with me (i.e., for purposes of case supervision, for purposes of "covering" for me when I am unavailable, for purposes of hospitalization or for emergency psychiatric services); 5) As required by state law; 6) If I were appointed by the court to evaluate/provide service to you; 7) If you were to file a suit against me for breach of duty.

Payment is expected at the time of service, and is appreciated at the beginning of the session as it allows us to spend our time on you. I accept cash, checks and MC/Visa. Please notify me as soon as possible and within 24 hours when canceling or rescheduling an appointment. The reason for doing this is that we have agreed to meet at a specific time and this time slot is reserved for you. Missed appointments or those canceled with less than 24-hour notice carry a charge of 75% of your regular fee. This fee is payable before or at the time of the next appointment. You, not an insurance carrier, are responsible for this charge.

I do not accept insurance, but will be glad to provide paperwork you can submit. You are responsible for knowing your insurance benefits, including knowing whether a mental health provider is on your plan, and the type of services covered by your plan. The services you receive may exceed the benefits provided in your insurance or managed care benefits package. Accounts due for over 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency and a surcharge will be added.

I check my voice mail throughout the day and return calls as soon as possible, usually within a couple of hours or at the end of my work day. For urgent matters feel free to contact me on my business cell phone (512) 567.6944. If you are in crisis or a life-threatening situation contact your doctor, psychiatrist, the Mental Health Hotline (472-4357) or go to the nearest emergency room.

Please let me know if you have any questions or problem with my services. It is most productive to work out concerns at the time they occur. I adhere to the ethical guidelines and practice standards published by the American Association for Marriage and Family Therapists in the AAMFT Code of Ethics. I am an LMFTA, Licensed Marriage and Family Therapy Associate (license #201226) and am supervised by Patricia Koch, Ph.D., LMFT. Questions about consumers' rights or complaints may be addressed to the Texas State Board of Examiners for Marriage and Family Therapists by telephone (512/834-6657) or by mail (1100 W. 49th St, Austin, TX 78756).

Keep a copy of Office Information for your records

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Fee Information

Policy
I have not chosen to work as a provider for insurance companies, but will furnish paperwork you may submit. You may want to contact your insurance provider and ask what your out-of-network mental health benefits are for more information about reimbursement. Please be aware that insurance companies require a diagnosis that becomes part of your insurance record.

Payment
Payment is greatly appreciated at the beginning of the appointment so that we may focus meeting time on you. I accept payment by check, cash or credit card (MC/Visa).

Initial phone consult	15 minutes	No charge
Individual Therapy	50 minutes	$85
Individual	90 minutes	$120
Couple/Family	50 minutes	$95
Couple/Family	90 minutes	$130
Telephone Contact	< 20 minutes	$20
Telephone Contact	< 30 minutes	$50
Telephone Contact	< 45 minutes	$75
Reports/Letters	< 20 minutes	$45
Reports/Letters	< 45 minutes	$80
Short Notice Cancel/No Show * (< 24 hrs prior to appointment. *Not covered by insurance.)		75% of regular fee

Fees are subject to periodic adjustment.

My signature attests to the following: 1) I have read the Office Information and Fee Information forms, and I consent to engage in counseling/therapy services; 2) if applicable, I authorize Asha Jane, LMFTA to release any pertinent information acquired in the course of my evaluation and treatment to my insurance company; 3) I understand I am financially responsible for non-covered services; 4) I understand that Asha Jane, LMFTA is not “on-call” after office hours or on weekends; 5) I understand that Asha Jane, LMFTA is a sole practitioner in independent practice and is not part of a group practice.

Signed____ Date__________________________
(Client)

Keep one copy of this contract for your records. Return one copy to me.

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HIPAA Notice of Privacy
April 2003

Patient Name______________________________ **Date of Birth**________________________

THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Private Health Information may be used and disclosed in the following circumstances:
1. When required for public health issues such as workman's compensation.
2. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
3. When required by any state or federal law, including abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits.

You as the patient have rights to your Private Health Information (PHI), including:
6. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
7. The right to request information of any party that has requested information pertaining to your private health information.
8. The right to receive confidential information regarding your private health information.
9. The right to revoke this consent in writing, however, this will not affect any information already disclosed.

I, as a private practitioner have the responsibility to:
10. Make each patient aware of the Privacy Notice.
11. At any time, make the necessary changes to Privacy Notice that are required by law.

If you as the patient feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I, ___________________________, hereby authorize Asha Jane, LMFTA to release private health

information on my behalf to the following person(s): ___________________________________

_______________________________________ ___________________________________
Patient/Legal Guardian/Signature **Date**

_______________________________________ ___________________________________
Witness **Date**

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Consent to the Use and Disclosure of Health Information for Treatment, Payment & Operation

I understand that as part of my healthcare, Asha Jane, LMFTA originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means for communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine operations such as assessing quality of care.

I understand and have been provided with a HIPAA Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Asha Jane, LMFTA reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment.
I understand that I may revoke this consent in writing, except to the extent that Asha Jane, LMFTA has already taken action in reliance thereon.

______ I request the following restrictions to the use or disclosure of my health information.

____

____

____

____

__________________________________ __________________________
Patient/Legal Guardian Signature Date

__________________________________ __________________________
Witness Date

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Authorization for Communication via Email

No information is ever sent electronically without prior written permission given by you or your legally authorized representative. You have the option to communicate with me via electronic mail (email) for non-urgent matters but you should be aware this is an exception to the HIPAA Privacy Rule and requires your authorization. Although my computer is password protected, I cannot and do not guarantee the privacy or security of any messages being sent over the Internet.

Please do not use email during emergencies or when in crisis: Email may be used to request general information and ask non-urgent questions. It should not be used in emergencies. If you are experiencing a crisis, please contact the Mental Health Hotline at 512.472.4357, call 911, or go to an emergency room.

Privacy and security of email: Do not use email to send or request sensitive information, particularly personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use email provided by your employer, any email sent on your employer's system might be accessible and read by your employer and possibly others at your work place.

There is the potential that email sent over the Internet can be intercepted and read by others or read by others who might have access to your computer or email account. If this is of concern to you, you should not communicate with me by email.

Authorization to use email
I have been informed of and understand the risks involved with using email and that while Asha Jane's computer is password protected, it is not to be considered secure. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email as one form of communication with Asha Jane, LMFTA.

Name (Print)____________________________________ Date___________

Signature______________________________________

Signature______________________________________ Date___________
Asha Jane, MA, LMFTA

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Release of Information Authorization

Patient Name ______________________ Date of Birth __________ Social Security Number __________________

To/From _______________________________ To/From __________________________

_______________________________________ __________________________________

_______________________________________ __________________________________

Type of Individual Identifiable Health Information:

____Psychological Assessment
____Initial Evaluation
____Termination Summary
____Progress in Treatment
____Treatment Plan
____Medical Information
____Vocational Information/Assessment
____School Records
____School Academic and Behavioral Data
____Special Education Evaluation & Records
____Legal Information
____Other__________________________

The Purpose for this Release:

____Legal Circumstances
____Continuity of Care
____Coordination of Treatment
____Insurance Purposes
____Disability Determination
____Vocational Rehabilitation
____Other ____

I understand that I can revoke my authorization at any time except that disclosure has already taken place, and if not previously revoked, this authorization will expire one year from the date signed.

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL ABUSE or MENTAL HEALTH TREATMENT.

PROHIBITION ON DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____ ________________________________

Patient/Legal Guardian Signature Date

ID Verified___________

____ ________________________________

Witness Date