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

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 cour 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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND INITIAL NEXT TO EACH PARAGRAPH.

_____ **I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or payment for this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and privacy policies at any time. Any changes will apply to PHI on file already. Before making any important changes to policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

_____ **II. HOW I MAY USE AND DISCLOSE YOUR PHI.**
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others I do not. Listed below are the different categories of uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. Your PHI may be used and disclosed without your consent for the following reasons:
1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with trainees, interns, and supervisors. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services you received or to evaluate the performance of health care professionals who provided services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.
4. Patient Incapacitation or Emergency. I may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think you would consent to such treatment if you were able.

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B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or claim for workers' compensation benefits, I may use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI.

_____ III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but am not legally required to accept them. If I do accept your requests, I will put them in writing and will abide by them, except in emergency situations. However, be advised that you may not limit the uses and disclosures that are legally required.

B. The Right to Choose How I Send PHI to You. You have the right to request that confidential information be sent to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail).

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I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me information as to how payment for such alternate communications will be handled. I may not require an explanation on the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have for you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will communicate in writing my reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, I will charge you no more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; or disclosures made to correctional institutions or law enforcement personnel. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe a mistake exists in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

_____ VI. HOW TO COMPLAIN ABOUT OUR PRIVACY PRA**CTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision made about access to your PHI, you may file a complaint with my office, as well as send a written complaint to the Secretary of the Department of Health and Human Services at: 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

_____ V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services that we cannot resolve, please contact DHHS at The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 1-877-696-6775.

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Revocation of Authorization to Release
Protected Health Information

I, _____, hereby revoke the authorization to release information I provided to Asha Jane, MA, LMFTA to use and disclose my protected health information as I outlined on the authorization form, which I signed on (date) _____ for release of my protected health information to (facility/person) _____. I understand that this revocation does not apply to any action Asha Jane MA, LMFTA has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorization to release information that I have provided to Asha Jane, MA, LMFTA.

_____ _____
Patient Printed Name Birth Date

_____ _____
Patient/Patient Representative Signature Date

_____ _____
If Patient Representative, Relationship to Patient Printed Name

SPECIAL PROVISIONS

In this section, any special provisions regarding the revocation of the authorization should be detailed. If there are none, indicate “none”.

_____

_____

_____

_____ _____
Patient/Patient Representative Signature Date