KATE V. SHEDDAN, MA, LPC
Phone: (512) 541-8207 katesheddan@yahoo.com

Welcome!

Welcome. The following information is provided to acquaint you with the policies of my private practice. Please, read carefully. Please, discuss any questions you may have about this agreement with me before you sign it.

Appointments: All psychotherapy sessions are 50 minutes unless we plan in advance to have a longer session. In most cases, you will be seen on a weekly basis or otherwise agreed upon. If you are late to your session, we will still end on time. If I am late, you will receive the full time.

Insurance and Monthly Statements: I am a provider for Ambetter, MMP/Allwell from Superior Healthplan, and Behavioral Health Medicaid/CHIP. If I don't accept your insurance, I can provide you with a monthly statement/Superbill that you can submit to your insurance company if you have "out of network" benefits.

Fees: Payment is due at the beginning of your appointment so that we can spend the entire time focusing on your therapy. The fee for individual sessions is $100 and $125 for a couple/family session. I accept payment by check or cash.

Cancellations & Rescheduling: Your appointment time is reserved for you. When you give me a full 24 hours advance notice of your cancellation by phone or by email there will be no charge.

IF YOU MISS YOUR APPOINTMENT OR CANCEL LESS THAN A FULL 24 HOURS IN ADVANCE YOU WILL BE RESPONSIBLE FOR THE FULL FEE FOR THIS APPOINTMENT.

Office Locations: My office is located at 3103 Bee Cave Rd., Suite 120, Austin, Texas, 78746.

Messages: My office phone is answered and messages received 24 hours a day at 512-541-8207 office. Always leave the phone numbers where you may be reached.

E-Mail: Be aware that e-mail is not a secure form of communication and your privacy cannot be guaranteed. Any communication regarding the content of your therapy sessions should preferably be done in person, not by e-mail. I do not engage in e-mail discussions with clients about their therapy.

Confidentiality: No information about the content of your therapy sessions will be communicated to anyone without your expressed and written authorization. The only exceptions to this are cases of child or spousal abuse or suicidal or homicidal emergency. I will give you an additional HIPPA statement for your review and signature.

Emergencies: For clinical emergencies only, you may call me on my cell phone at (512) 541-8207. For emergency related phone calls, I provide up to 15 minutes per week at no charge. Any emergency related phone calls with clients, family, professionals, and treatment facilities above the weekly limit will be charged my regular rate. If you are unable to reach me during a psychiatric emergency, you are to contact your physician, the Travis County Mental Health Hotline 512-703-1390, crisis info@atcic.org), or go to the nearest hospital emergency room or call 911.

Other Services: Fees for written reports are based on the amount of time required to complete the report. I have a separate fee schedule for written reports, hospital and home visits and services related to legal matters, such as depositions, court appearances, etc.

Termination: If you begin therapy with me, I ask that if you decide to stop your therapy at any time, it is important that you do this in person with me rather than by phone, letter, voice mail or text. As with any relationship, in therapy it is important to begin and end in a direct and honest way in order to feel positively.

BASIC CLIENT RIGHTS

1. You are entitled to know your therapist's credentials, training and experience.
2. You have the right to ask questions about the services at any time.
3. You may terminate services at any time.
4. You may refuse services, or a part of services, at any time.
5. Confidentiality:

Participants are entitled to confidentiality about their identities and other information shared in sessions. In order to provide the best condition for therapeutic work, children and adolescents must be provided confidentiality regarding what they reveal.

Limits to confidentiality include:

1. when the participant is believed to be in imminent danger to him/herself or others;
2. when legally required to report abuse or neglect of children, disabled or elderly;
3. when records are court ordered by a judge; or
4. when you provide your written consent.

Your signature indicates that you have read the information in this treatment contract, understood it, and that you agree to comply with these policies. My signature indicates that I have reviewed the terms of this contract with you and agree to provide my services within the terms stated in this contract.

_____ _____

Signature **Date**

_____ _____

Signature **Date**

Directions to my office:

Office is at 3103 Bee Cave Road, Suite 120(Center One), corner of Old Walsh Tarlton and Bee Cave Road. Turn South onto Old Walsh Tarlton and drive into the second driveway on your left. After you enter the courtyard walk to your right and you will see Suite 120. You will find a light switch with my name on it in the waiting area. Please switch it on and I will know that you have arrived. Bring the completed forms to the first session.

Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices for Protected Health Information

This notice describes how information about you as a client of this practice may be used and disclosed and how you can obtain access to this information. Health care providers are required by a federal regulation, the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices. This office will not use or disclose your health information except as described in the Notice.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of (1) treatment, (2) payment, and (3) healthcare operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a chart and on a computer. Such information may include documenting your symptoms, medical history, evaluation, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. Our office is also permitted to use or disclose health information in the following instances:
1) Appointment reminders and/or appointment changes.
2) Release of information to family or friends who are closely involved in your care.
3) Disclosure of information when required to do so by Federal, State, or local law.
CONFIDENTIAL COMMUNICATIONS: You may request that our Practice communicate with you in a particular manner or at a certain location. For example, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
RESTRICTIONS: You may request a restriction in our disclosure of your health information for treatment, payment, or our healthcare operations. You may request a restriction to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request. You must include the information you wish to restrict, whether you are requesting to limit use, disclosure or both and to whom you want the restrictions to apply.
INSPECTION AND COPIES OF RECORDS: Psychotherapy records are excluded from the right of the client to access his/her health information. Copies of records can be sent with the written consent of the client to another therapist, doctor or attorney.
AMENDENT: You may request an amendment to your health information if you believe it is incorrect or incomplete. Such a request must be made on a form provided by the office. You must provide a reason for your request. We may deny your request.
ACCOUNTING OF DISCLOSURES: This is a listing of certain, non-routine disclosure of your information not for treatment, payment or operations purposes, disclosures made at your request, pursuant to an authorization signed by you, disclosure to family members or friends relevant to that person's involvement in your care or in payment for such care.

You have the right to review this Notice before signing the acknowledgement authorizing use and disclosure of your protected health information for treatment, payment, and healthcare operations purposes.

OUR RESPONSIBILITIES: The office is required to maintain the privacy of your health information as required by law; to provide you with this notice as to our privacy practices as to the information we collect and maintain about you, to abide by the terms of this Notice, to notify you if we cannot accommodate a request, and accommodate reasonable requests regarding methods to communicate health information about you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protect health information. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by request. Note: A more complete version of this information can be found on the brochure. Please review it at your first opportunity or request a copy.

I acknowledge that Kate Sheddan has made available to me the Notice of Privacy Practices that fully explains the uses and disclosures that Kate Sheddan, LPC may make with respect to my individually identifiable health and sensitive personal information.

Name: _____ **Date:**_____

Signature: _____ **Relationship: (circle) Self Guardian Parent**

PARTICIPANT CONFIDENTIALITY FORM

Participant Name: _____

Occasionally, it is necessary for our office to call to discuss insurance information, coordinate/discuss referral to another physician, or schedule/cancel appointments.

Please list the family member/other person, if any, whom we may inform, discuss or leave messages with about your appointments. This is only necessary if we cannot reach you:
Name _____ Relationship_____

Name _____ Relationship_____

Please print the telephone number where you want to receive calls about your appointment scheduling/cancellations if other than your home phone number:
Work _____ Cell _____

Email _____ Pager _____

Other _____

Can confidential messages (i.e., messages to call the office regarding appointments) be left on your home answering machine or voicemail? YES __ NO __
in your email? YES __ NO __
cell phone (text message or voicemail) ? YES __ NO __

Can we call you at your place of employment/school if you cannot be reached at home?
YES _____ NO_____

Would custodial parent need to be notified if non-custodial parent requests copy of medical records.
YES _____ NO _____ NA _____

Acknowledgement of receipt of Notice of Privacy Practices:
YES _____ NO _____

PARTICIPANT NAME (Print) _____

(SIGNATURE) _____ Date_____

Please Circle one – Participant / Guardian / Custodial Parent

CONSENT TO DISCLOSURE OF CLIENT RECORD INFORMATION

Name of Client: _____ Date of Birth:_____ Social Security Number: _____Name of Covered Person: _____ Name of Insurance: _____Name of Insurance Plan: _____

Member ID Number: _____Group Number: _____

Employer's Name: _____Other: _____

This authorizes Kate Sheddan, LPC to release or disclose to the third party payer information from the records of the above referenced client.

This information to be disclosed is limited to: Medical information necessary to process a third party claim.

The purpose of disclosure is: To request payment of third party benefits to Kate Sheddan, LPC.

Assignment of Benefits: I authorize _____
(Name of Third Party Payer)

to assign benefits for this claim to the provider of service, Kate Sheddan, LPC. Please send payment directly to Kate Sheddan.

This consent to disclosure is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This consent is valid for one year from the date signed.

Signature: _____ Date: _____
(Client or Guardian)

Title: _____
(Client, Parent, Guardian, Executor, Administrator, Managing Conservator, Surviving Spouse)

Signature: _____ Date: _____
Kate Sheddan, LPC

Email / Texting Consent

By signing below, I grant permission for KATE SHEDDAN to communicate with me by email or by cell phone text message. I understand that e-mails/texts are not a secure form of communication, are not encrypted and that confidentiality of any e-mailed/ texted information cannot be ensured. I also understand that any email and text communication between me and KATE SHEDDAN may become a part of my file.

I understand that it can take as long as three (2) working days for KATE SHEDDAN to respond to email or text messages, so urgent or sensitive information should be communicated in person or by phone call. (IN AN EMERGENCY, CALL 311 or 911 – DO NOT USE EMAIL OR TEXTING.)

I understand the risks involved with e-mail/text messaging and that KATE SHEDDAN cannot guarantee confidentiality of this form of communication.

I understand that I may revoke my Consent at any time by signing the Revocation of Consent at the bottom of this form. Check all that apply:

☐ KATE SHEDDAN may send email messages to _____

☐ KATE SHEDDAN may send cell phone text messages to _____

Please let us know if your contact information changes.

_____	_____	_____
Client Signature	Printed Name	Date
_____	_____	_____
Parent / Guardian Signature (if client is a minor)	Printed Name of Parent / Guardian	Date

Revocation of Consent

By signing and dating below, I hereby revoke my consent for any email or text communication with KATE SHEDDAN

_____	_____	_____
Signature	Printed Name	Date

Risks of Email and Text Communication
Communication by e-mail or texting has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.
- Email and text communication can be used as evidence in court.

HOW WE WILL USE E-MAIL AND TEXT COMMUNICATION

1) We will limit e-mail and texting to clients who are adults 18 years or older, or minors with parental consent.
2) We will not use e-mail or text to communicate with you about personal health information.
3) All e-mails to or from you may be made a part of your record and may be viewed by other Jung Wellness Institute staff as a part of providing services to you.

We will not disclose your e-mails to others outside of Jung Wellness Institute/Anita Jung unless allowed or required by state or federal law. Please refer to our Notice of Privacy Practices for information on how your information may be used and your privacy rights.

KATE V. SHEDDAN, MA, LPC
Phone: (512) 541-8207 katesheddan@yahoo.com

CLIENT INFORMATION

Client Name(s) (Please Print) Date of Birth
Marital Status

Street Address City/State Zip Code Home Phone # Cell Phone #

Client's Employer Occupation (Indicate if Student) How long employed?
Business Phone #

Employer's Address City/State Zip Code Client Driver's License #

Best number and time to reach you: E-mail address

Education

In case of emergency, contact (name, relationship and phone number):

Who referred you to this practice?

May I have your permission to thank this person for the referral? Yes No

Primary Care Physician Phone #:

Are you taking medications? If yes, please list:

Spouse's Name		Date of Birth
Spouse's Employer Phone #	Occupation (Indicate if Student)	Business
Employer's Address	City/State	Zip Code

Where were you born?

Where were you raised?

Who raised you?

How many siblings do you have?

Have you ever been in therapy before? _____ If yes, please list the name of the therapist(s) you have seen in the last 3 years and the approximate year(s) you saw them: _____

Why are you seeking therapy at this time? _____

What goals do you have for therapy? _____

What do you consider to be your greatest strengths (inner qualities, talents, or skills)? _____

How many or who of your friends or family members do you consider to be part of your support system?

In what way are they supportive?

Please, list anything else that you think might be helpful for you to discuss at our first meeting?

PAYMENT/CANCELLATIONS/CONFIDENTIALITY

Payment by check or cash is due at the beginning of each appointment.

Cancellations: If you notify me a full 24 hours before your scheduled appointment, you will not be charged. If you don't receive confirmation from me, that means I have not received your call, e-mail or text. You will be charged your full fee if I do not receive 24 hour advance notice of cancellation from you.

Confidentiality: All information shared in our session will be kept confidential unless you are determined to be a danger to yourself or others.

Please ask if you have any questions and thank you for completing this form.

I, _____, authorize the release of any medical information necessary to process this claim and the payment of medical benefits to **KATE SHEDDAN, MA, LPC.**

Signature: _____
Date:_____

Signature: _____
Date:_____