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"Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

I respect the information that you share with me during the treatment process, and want to protect the confidentiality of all information shared, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. Also, Texas State Law mandates that if child abuse or neglect is suspected, or if my records are subpoenaed by the court (e.g., in a child custody suit), or if you file a suit or complaint against me, I may, and in some cases, am required to, disclose the information you share in confidence.

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. **However, I do not routinely disclose information in such circumstances, so I will require your permission in advance through your consent at the onset of our relationship** (by signing the attached general consent form), **and inform you of my need to disclose information at the time the need for disclosure arises.** You may revoke your permission, in writing, at any time, by contacting me.

NOTE TO SETON HEALTH PLAN CLIENTS: In order for me to seek reimbursement for services provided to you, I routinely provide Seton Health Plan with the dates of our sessions and your diagnosis.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important
exceptions to this rule of
confidentiality

If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Texas law to report the matter immediately to the Texas Department of Family and Protective Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Texas law to immediately make a report and provide relevant information to the Texas Department of Family and Protective Services.
- **Health Oversight:** Texas law requires that licensed psychologists [social workers] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Texas Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

III. Patient's Rights and Provider's Duties:

- **Right to Request Restrictions**—You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- **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. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- **Right to an Accounting of Disclosures** – 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 written request, I will discuss with you the details of the accounting process

Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

Emergency Availability: I do not provide coverage for emergencies on a 24-hour basis. In the event of an emergency, please contact the 24-hour Psychiatric Hotline of **Austin Travis County Integral Care at 512-472-4357.**

Course of Treatment: An initial 60 minute evaluation will be conducted in the first session to explore the issues that bring you/your family to therapy. During this session, we will decide whether continuing treatment is appropriate at this time. If it is mutually agreed to continue in a therapeutic relationship, the next several sessions will focus on clarifying issues to be addressed in treatment, as well as setting treatment goals.

Fees: My fee for a 50-minute session is \$150 for individual and \$165 for couples where payment is due at the time of each session. I take **CHECK or CASH only.** I do not accept third party billing. If you wish to be reimbursed by your insurance carrier, you will need to file your claim directly with them. I provide a formal billing statement at the end of each month, upon request, you can submit to your insurance company to obtain your allowed reimbursement. I understand that situations may arise unexpectedly making it impossible to avoid canceling your session. Any appointment cancelled 24-hours prior to your session may be rescheduled without an additional charge. **Appointments that are cancelled less than 24-hours before the appointment time will be billed at the full session rate to be paid for in full at the time of your next scheduled appointment, as your appointment time is held exclusively for you.**

Confidentiality: Court, Custody and Other Legal Matters: My expertise lies in my therapeutic training and skills, and I do not appear in court as an expert witness. If you or your family are currently or become involved in legal proceedings, please note the following: I charge a fee of \$225 per 60 minutes for any court-related communication with you, your attorney or opposing counsel, as well as for my time spent preparing for any communication or documentation. My billing fee also applies to time spent for depositions and court appearances if I am subpoenaed.

Patient's Acknowledgment of Receipt of Notice of Privacy Practices

I have been provided a copy of Jennifer Jones' Notice of Privacy Practices

Consent: By signing below, you acknowledge and agree that: (i) you have read the above information and understand it; (ii) you agree to the arrangements as outlined; and (iii) you are voluntarily requesting and authorizing Jennifer Jones to deliver therapeutic services, treatment, and/or referral based on her clinical judgment.

Client Signature
Date

Client Printed Name

Jennifer Spradley Jones, LCSW
Date
