NEW CLIENT – REGISTRATION PACKET

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Email: _____ Preferred Phone #: _____ DOB/Age: _____

Gender Identity: _____ Race: _____

Employer/Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone number: _____

CURRENT MENTAL HEALTH

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

_____

_____

What are your goals for counseling?

_____

_____

MENTAL HEALTH HISTORY

Have you ever seen a mental health professional before? If yes, please specify dates, reason for counseling, and your experience.

_____

_____

Prior history of mental health diagnosis? If yes, what, was it treated, is it ongoing?

_____

Have you been hospitalized for a mental health issue? If yes, when, where, and for what reasons?

_____

Specify all medications and supplements you are presently taking and why.

_____

Have you ever had suicidal thoughts? If so, describe.

_____

_____

Have you ever attempted suicide? If yes, please describe.

Current or past self-injurious behavior? Describe.

FAMILY/SOCIAL HISTORY & INFORMATION

Parents' relationship status: _____

How would you describe your relationship with your parents? Please specify.

Do you have sibling(s)? Please provide age(s) and current relationship(s).

History of verbal, physical, or sexual abuse? Please only share what you're comfortable with.

History of significant losses?

Describe your social support system.

Describe your current living situation (e.g., I live alone, with roommates, with family).

Is there a history of mental illness in your family? If yes, please describe.

Current relationship status: _____

SUBSTANCE USE/ABUSE HISTORY

Tell me about any personal history of substance use. Describe type, frequency, volume.

Do you have concerns about your alcohol or substance use? If so, please describe.

EATING BEHAVIOR & BODY IMAGE

What is your relationship like with food? Do you have concerns about your eating patterns/behaviors?

Does your weight/shape/appearance affect the way you feel about yourself?

What is your relationship like with your body?

What is your relationship like with exercise?

OTHER

Do you have any medical issues?

_____

Are there any other mental health and/or health professionals that you see that you'd like me to collaborate or connect with? Please list.

_____

What else would you like me to know?

_____

_____

_____

THERAPIST-CLIENT SERVICE AGREEMENT

PSYCHOLOGICAL SERVICES: WHAT TO EXPECT

My hope as a therapist is to provide you with a uniquely safe space in which you can be the fullest, most genuine version of yourself. You can expect that I will meet you where you are (wherever that might be), that I will listen non-judgmentally, that I will respect you and your story, that I will do my best to understand your concerns and your perspectives, and that I will validate your experiences. You can also expect that I will adapt to your needs and use a variety of techniques and strategies to help you. I am a firm believer in interactive therapy and believe that both the therapist and client should be participating in the therapy relationship; thus, our sessions will be dynamic and reciprocal.

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right counselor for you. You are free to leave therapy at any time.

CONFIDENTIALITY:

Other than the specific exceptions described below, you have the absolute right to the confidentiality of your therapy. What you share with me during therapy is between us and will not be discussed with others without your prior written or verbal permission. My objective will always be to protect your privacy, even if you permit me to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

The following are legal exceptions to your right to confidentiality:

1. If I have cause to believe that you are in danger of harming yourself or someone else or have made threats to harm yourself or something else;
2. If I have cause to believe that a minor or elder person has been, or is being, abused or neglected;
3. If I am legally compelled to disclose information;
4. If you disclose to me that you have been sexually abused by another mental health professional or member of clergy;
5. I am always seeking to provide you with the most comprehensive, evidence-based care. Thus, I may consult with other health and mental health professionals about your case. However, I will provide only the necessary details and avoid providing any revealing or identifying information;
6. You should be aware that APA employs administrative staff that have access to protected information for clinical and administrative purposes (e.g., scheduling). It should be noted that all staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

If any of these situations occur, I will make every effort to discuss it with you in full before taking any action and I will limit my disclosure to what is absolutely necessary.

HOURS

- I offer late morning, afternoon, and evening hours on 4-5 days per week. I also offer Saturday hours as needed.
- Hours are subject to change on occasion and you will be informed in advance if this occurs. You will also be informed in advance about vacations and time out of office.

PHONE CALLS/EMAILS

- Austin Psychotherapy Associates' main number is **(512) 231-0164.** The office number is answered by staff during business hours and by a recording after hours.
- After hours and on Fridays, Saturdays, and Sundays, an answering service will direct your call to me or the person covering for me.
- The answering service phone number is **(512) 404-9098** and is on our office recording.

- I can also be reached via e-mail at JLSprengleLPC@gmail.com.
    - However, it should be noted that e-mail is not confidential and I cannot guarantee the privacy of electronic communication.

HOWEVER, I am not always immediately available; thus, in the event of an emergency, **please call 911 or visit your nearest ER**. Additionally, in the event that I am ill, on vacation, or at a location where telephone access is unavailable, I will provide you with backup numbers of alternative counselors or therapists you may call.

CANCELLATIONS

- I ask that clients please provide me with at least 24 hours notice should they need to cancel and/or reschedule an appointment. A client is responsible for payment of the full charge of the session if the session is missed and/or canceled without appropriate notice.
- This policy does not apply to cancellations made due to illness, emergencies, and other understandable reasons.

BILLING

- All charges are the responsibility of the client/client's parent regardless of insurance coverage or rate of reimbursement. Payment can be made via check, cash, and/or via Stripe/credit card.

    - *Initial evaluation* (between 50 and 90 minutes) = $165
    - *Follow-up sessions* (50 minutes) = $150
    - *Missed sessions or canceled sessions without 24-hr notice* = $150

- **Checks are to be made out to Jessica Sprengle.**

- I am not currently in-network with any insurance companies. I am considered an "out-of-network provider." I advise you to check your insurance benefits as early as possible. If you are struggling with this, we can call your insurance company together during session.
- If you have health insurance, your policy may include benefits for out-of-network providers, and provide reimbursement for our sessions. Regardless of what your insurance pays, you are ultimately responsible for the full amount of your sessions. Should your insurance company provide reimbursement, I can provide a specialized receipt (either per session or per month) for you to submit.
- I offer sliding scale and cost of sessions can be negotiated on a case-by-case basis.
- My primary concern is always the well-being of the client and maintaining the therapeutic relationship. It is my hope that payment and/or issues around payment never interfere with that! Please contact me as soon as possible if you have any concerns about payment or fees.

I work with a group of independent mental health professionals, under the name of Austin Psychotherapy Associates. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

By signing below, I am agreeing that I have read these forms, have had sufficient time to be sure that I considered it carefully, have asked any questions that I have needed to, and have understood it.

_____ _____

Client signature **Date**

_____

Jessica Sprengle, LPC

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_____ _____

Client signature **Date**

_____

Jessica Sprengle, LPC

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I, _____, authorize _____

to release and/or exchange information about my case with the following parties:

Name/Relation: _____

Address: _____

Phone Number: _____

Information to be Released or Exchanged
(check all that apply)
_____ Intake and history
_____ Treatment Progress
_____ Diagnosis and Treatment Plan
_____ Discharge Summary
_____ Verbal Consultation
_____ Billing & Payment
_____ Other (specify)_____
_____ All of the Above

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment.

Client Name & date:

_____
Client Signature:

_____
Parent Signature if under 18

_____

NOTICE OF PRIVACY PRACTICES
(The following is a summary. The full text is located in our waiting room.)

We at Austin Psychotherapy Associates are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. (See restrictions in the full text.) You must submit your request in writing to the Privacy Officer.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact Gayle Harkrider, Privacy Officer, at:

4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

PATIENT COPY

This notice is effective November 14, 2006.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.