Katie Porter, M.A., LPC, PLLC, CNFC, EMDR and Brainspotting Trained
1525 Lakeville Drive, Suite 217
Kingwood, Texas 77339
Phone: 832-298-6356
Email: k.b.porter@protonmail.com

Eating Disorders Initial Intake – Child or Adolescent

Today's Date: _____
Client's Name: _____ Email: _____
Date of Birth: _____ Age: _____ Male _____ Female_____

Presenting Problem

In your own words, why are you bringing your child into therapy?

_____
_____
_____
_____
_____

Has your child ever been diagnosed with an eating disorder? If so, please check all that apply:

_____ Anorexia Nervosa _____ Bulimia Nervosa _____ Binge-Eating Disorder

_____ (check here if purging behaviors accompany any of these)

Family History

What would you like to share about your family? (You can include immediate, extended, blended, etc.)

_____
_____
_____

Does your child get along with members of your family?

_____
_____

Is the child's family aware of any changes in her mood, thoughts, behaviors, or eating habits?

_____
_____

Is there a family history (maternal or paternal) of mental illness, eating disorders, or addiction?

_____
_____

Weight, Eating, and Diet History

What is your child's current weight? _____ What is her weight goal? _____

What was your child's weight and eating like when she was younger?

_____
_____

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Does she feel like she has done things to try and lose weight on purpose?

_____

_____

What is an example of a "good day" of eating and a "bad day" of eating for your child?

_____

_____

Does any family member's eating habits or body image negatively contribute to your child's eating disorder?

_____

_____

Personal Goals

What are your goals regarding the recovery of your child?

_____

_____

Would you like your child to like to feel less obsessed/preoccupied with food?

_____

_____

Would you like your child to have a healthier relationship with food?

_____

_____

Social Support

To who does your child usually go to for help for any issues she might be facing?

_____

_____

Who does she feel really cares about her?

_____

_____

How much does this supportive person know about her current situation?

_____

_____

Psychiatric History

Check all that apply to your child, in the past 12 months:

____Depression ____Change in relationships ____Hearing Voices ____Dizziness

____Frequent Crying ____Changes in sleep ____Anxiety ____Drug or alcohol use

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____Frequent weighing-in ____Food restriction ____Bingeing ____Purging

____Isolation ____Suicidal Thoughts ____Obsessive-compulsive behaviors

____Perfectionism/Very high standards ____Easily irritable ____Headaches

____Excessive Exercise ____Use of laxatives or diuretics ____Racing thoughts

Has she ever threatened or attempted suicide? If yes, please explain and include approximate timeframe:
_____
_____
_____

Please list any medications your child is currently taking, including the dosage:
_____
_____
_____

Substance Use

Has your child ever used drugs or alcohol (including diet pills, laxatives, diuretics) to your knowledge? Explain:
_____
_____

Does your child currently use any drugs or alcohol (including diet pills, laxatives, diuretics) to your knowledge? Explain:
_____
_____

Trauma History- Sexual/Physical/Emotional/Verbal Abuse and Neglect

Please check all that apply:

_____Sexual Abuse _____Physical Abuse _____Emotional Abuse _____Verbal Abuse _____Neglect

If yes, please explain:
_____
_____
_____
_____

How is your child disciplined?
_____
_____

Who is the main disciplinarian? _____

Does she feel safe in her environment? _____

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If so, with whom does she feel most safe? Why?
_____

Insight, Effort and Motivation Levels

Do you think your child needs help for her eating disorder?
_____
_____

Do you believe that she might be out of control with her relationship with food? In what ways?
_____
_____

Do you think you might be aware of some underlying causes of her eating disorder? If so, explain:
_____
_____
_____
_____

What have you or a professional done to try and alleviate the problem? Did anything help? What did not help?
_____
_____
_____
_____

How motivated and committed is your child to getting help for her eating disorder and getting well? (0= not at all, 10= the highest you could imagine)

0 1 2 3 4 5 6 7 8 9 10

It is important to have a treatment team including a counselor, psychiatrist and registered dietician. Are you interested in having a cohesive treatment team to best help your child? _____

I already have these:

Psychiatrist Name and Phone Number: _____
Dietician Name and Phone Number: _____

What Are Your Goals For Your Child's Treatment In Therapy? (Treatment Plan)

1. _____
_____
2. _____
_____
3. _____
_____

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Religious Affiliations or Beliefs?
_____

Would you like me to incorporate Christian belief into treatment? _____

Is there anything else you would like to share?
_____
_____
_____

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INSURANCE AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers, billing agents and/or other health practitioners as is required for authorization or billing purposes.

I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of client or parent if client is minor Date

Insurance Information

Name of Insured_____

Insured's Birthday_____

Insured's Address _____

Phone#_____

Relationship to Patient_____

Employer _____

Date Employed _____

Insured's Social Security #_____

Insurance Company_____

Policy ID # _____

Policy Group # _____

Phone # for Insurance _____

Patient's Name _____

Patient's Soc. Sec. # _____

Patient's Birthday _____

Primary Care Physician _____

Co-pay Amount $ _____

Number of Visits Allowed _____

Pre-Authorization # _____

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Client Registration

Today's Date: _____
Client Name: _____ Email: _____
Date of Birth: _____ Age: _____ Male ____ Female_____

Address: _____
City/State/ZIP: _____
Employer/School: _____ Occupation: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____

Who lives in the same home with client:
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

If client is a minor:
Parent Name: _____ Phone: _____
Parent Name:_____ Phone: _____
Step-parent Name:_____ Phone:_____
Step-parent Name:_____ Phone:_____

Emergency Contact
Name: _____Relationship: _____
Address: _____ Phone: _____

Has client ever seen a mental health provider? ____Yes ____No
If yes, who: _____ when: _____

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PLEASE READ THE INFORMED CONSENT CAREFULLY, INITIAL AND SIGN IN APPROPRIATE PLACES. WE WILL REVIEW THIS TOGETHER DURING YOUR FIRST SESSION

Informed Consent and Practice Policies for Office and Online Therapy

Welcome! I am pleased that you have chosen me to be your mental health professional. This document answers many questions clients often ask about counseling both in the office and with the new technology of online therapy, and explains procedures, financial policy and the privacy policy used in the practice of **Katie Porter, M.A., LPC, PLLC**. After reading the agreements and practices, we will discuss your questions and clarify any concerns before you sign our working agreement to begin services. Please ask about any part of the agreements and practices that you do not understand.

Counseling Process and Relationship – I believe that counseling is an interactive process between counselor and client and includes active listening, honesty, trust and mutual respect and completing outside assignments when appropriate. It also includes openly discussing concerns about the counseling process. An effective counseling relationship involves developing a healthy relationship with clear boundaries. I believe that my job as counselor is to help the client find his or her way through what may be difficult times or situations. And although ultimately only the client can direct his or her path, I am supportive, understanding and caring through the counseling process and treat each client as an individual with individual needs. Please know that I am a professional that is committed to your well-being.

It is important to understand that we have a professional relationship. If I see you in public, I will protect your confidentiality by not acknowledging or approaching you. I will wait for you to speak to me before I acknowledge you. I will not discuss your case in any public place. Contacts, other than chance meetings will be limited to scheduled appointments.

If you are coming to therapy appointments in my office, the first session we will discuss your presenting concern, your history and will discuss the goals you want to accomplish. If I am meeting with a minor, I will ask to first meet with the parent or guardian to discuss the above-mentioned items and the unique issues of confidentiality with a minor. Initially, counseling often results in the client experiencing uncomfortable feelings or thoughts. Sometimes things get harder before they get better. This experience may affect the client's relationship with family members, spouse, or other significant relationships. **When you bring your child for counseling, it is imperative that you stay in the building during the session. I must be able to find you in case of emergency.** If one parent has custody of the minor then documentation identifying the managing conservator will be required before treatment begins. If you qualify for counseling via online therapy, it is preferable that you come into the office for the first session, then the following sessions may be scheduled online.

The number of sessions needed will depend upon the circumstances that are taking place in each person's life. Each person's journey and struggles are unique, and each person moves at a different pace. Some clients may require only a few sessions in order to reach their goals while others may take several months or possibly even longer. You, the client, are in complete control. You may choose to end our professional relationship at any time. When you are ready to terminate therapy, please allow at least one session so we can have closure. If you find that my particular style of therapy does not meet your needs, please feel free to come to me first with your thoughts, and you may ask for referrals to other therapists.

In-Office Therapy Fees –

In-Office Therapy Fees –

55 Minutes- $150 85 Minutes- $220 115 Minutes- $300

Any phone consultations over 15 minutes will be billed at individual session rate in 15-minute increments.

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Payment by cash, credit card, or check is due at the time of your session. A $35 charge will be due for all returned checks. If you are late for a session, you will be given the remainder of the session and will be charged for a full session. Professional services include, but are not limited to, office appointments, therapeutic phone calls, letters, third party consultations, correspondence, and reports and will have a fee of $150 per hour and will be prorated accordingly. There is an appropriated charge for extra paperwork including but not limited to FMLA and disability. Other services requiring payment may include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. I reserve the right to change my fees and will notify you in writing at least sixty days prior to the change in rates.
Initial _____

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Online Therapy Fees- My fee is $150 for a 53 minute session for adults and 45-55 minutes for children. The initial intake session fee is $150 and it is preferred that you come into the office for the initial intake session, if possible. Payment by credit card is due at the time of your session. If you are late for a session, you will be given the remainder of the session and will be charged for a full session. Professional services include but are not limited to, office appointments, therapeutic phone calls, letters, third party consultations, correspondence, and reports and will have a fee of $150 per hour and will be prorated accordingly. I reserve the right to change my fees and will notify you in writing at least sixty days prior to the change in rates.
Initial _____

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (including but not limited to divorce and custody disputes, injuries, lawsuits, etc.), you agree that neither you, your attorneys or anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court or in any legal proceeding. By your signature below, you agree to abide by this agreement.
Initial _____

If I am subpoenaed to provide records or testimony in violation of this agreement, you acknowledge and agree that you will pay for all of my professional time, including preparation and transportation charges, regardless of which party issues the subpoena or requires me to testify.

If I am required to testify in court or give a deposition, the hourly fee is $400 per hour for a minimum of 4 hours and this includes preparation time, travel time and attendance at any legal proceeding. If the testimony or deposition exceeds 4 hours there will be an additional charge of $400.00 per hour for every hour or portion of an hour spent in court or deposition.

When I go to court or give a deposition, I have to clear my schedule and not see other clients, so there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than Noon on the Thursday before. Any cancellations that occur within the 48-hour time frame of the court appearance or deposition are **NON-REFUNDABLE**.

I will accept cash, money order, cashier's check, MasterCard, Visa or Discover for payment of time related to court appearances or deposition. **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES**. All payments are

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due 48 hours prior to the scheduled court appearance or deposition, and no later than 12:00 Noon on Thursday if the court hearing/deposition is scheduled for a Monday.

If I am subpoenaed by one party to provide records or testimony in violation of this agreement, I also reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT provide custody evaluations or recommendations regarding access to or visitation with minor children. I will NOT provide medication or prescription recommendations. I will NOT provide legal advice. None of these activities are within scope of my practice.

Court Appearances - My focus in providing counseling and psychotherapy is on treatment and healing. It is NOT my intention to become involved in cases that require evaluation (either written or otherwise) or my testifying in court. You should hire a different/neutral mental health professional for any evaluation or testimony you require. If you choose to involve the legal system in our work together by issuing a subpoena for my treatment records or my testimony in court, this will represent a conflict of interest for me, and I will terminate our therapeutic relationship and provide referrals to other providers. This position is based on two main reasons: 1) My statements may be seen as biased in your favor because we have a therapeutic relationship, and 2) The evaluation/testimony may affect the therapeutic relationship and that relationship must come first. This applies to clients of all ages. If I am required to appear in court or conference via telephone, the CLIENT/GUARDIAN will be REQUIRED to pay my fees listed above.

Cancellation and Missed Appointments - Since scheduling an appointment involves reserving a time specifically for you, a 24-hour advance notice is required for cancellations. If you cancel less than 24 hours before your appointment, you will be considered a NO SHOW for that visit and you will be charged the FULL FEE for that session. Once you have two NO SHOW appointments, you will be required to secure any subsequent appointments with a credit card. Subsequent NO SHOW appointments will be charged the FULL FEE for the missed session. By initialing, you agree to these terms.
Initial _____

Health Insurance – If you are requesting that I bill your insurance, please fill out the Insurance Authorization and Release form. **You are responsible for all fees not covered or reimbursed by your insurance benefits**, including but not limited to, deductibles, co-payments, missed appointments, late cancellations, correspondence/reports or services not approved by your plan. It is your responsibility to determine eligibility and to determine what services are allowable under your plan. If I am not a provider for your insurance plan, you may have out-of-network benefits through your insurance company. If you have such benefits, I can provide you with a receipt that you may submit to your insurance so that you can request reimbursement. If at any time your insurance information changes, it is your responsibility to update this information as quickly as possible. Back-dated reimbursement will not be given.

Online Therapy Insurance- In most cases insurance does not accept online therapy as a covered form of treatment, so I do not accept insurance as a form of payment with online therapy. The client is responsible for private payment in the form of a credit card or flexible spending account card at the time of, or before the services rendered. It is the client's responsibility to find out through their insurance if they can obtain partial reimbursement with out-of-network benefits. If this is the case, I will more than gladly supply the client with a superbill that he/she can submit to the insurance carrier.

Telephone Accessibility – I make every effort to respond to my messages promptly. I will not interrupt sessions to answer phone calls. Calls are returned during normal business hours, and I typically return calls within 24 hours. Because technical difficulties do sometimes occur, please call again if you do not receive a return phone call by the end of the next business day.

Emergency Care - If you are experiencing an emergency and need to talk to someone immediately, call 911, a telephone crisis line, or go to the nearest emergency room. I must emphasize that I am not a crisis counselor. If you would like to

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communicate your emergency to me, that is fine but we will discuss it during our next scheduled appointment. If I am out of town, I will provide you with a therapist's name and number of whom you may call in the case that you need to speak with a therapist. By initialing here, you agree to consent your information to this therapist as a temporary means of coping with an mental health issue.
Initial _____

Electronic Correspondence –
I use encrypted e-mail with clients. If you need to discuss a clinical matter or administrative matter between sessions please call me or email me. I use an encrypted, password-protected email platform to help and protect your messages. Use of my encrypted e-mail is allowed for administrative purposes only, not for counseling purposes. Any e-mails you send to me will be printed and will become part of your clinical record.

I do not text with clients. If a text is sent to my telephone number, it will be deleted without being read. All clients should contact me by telephone or email for any substantive matter relating to their therapy.

In addition, any phone consultations over 15 minutes will be billed at individual session rate in 15-minute increments.

Information about Online Therapy Services

Utilization of Online Therapy- Online therapy is a newly emerging and wonderful way to help individuals get the help they need when it may not be feasible to come into a therapist's office for a number of reasons. Online therapy, while it may be suitable for many, is not recommended for everyone's needs. If I assess that you would benefit more from face-to-face therapy I will offer an appointment or provide you referrals.

When should I seek traditional mental health treatment rather than online therapy?
It is important to note that online therapy is intended to provide quality information, practical answers to psychological issues, and online therapy for presenting problems. This service is not intended to provide in-depth psychotherapy as this particular venue is not entirely suited for such purposes.

- If you are having thoughts of harming yourself (self harm, suicidal thoughts), or someone else (violent thoughts towards others), or psychotic symptoms. Please call 911 or 1-800-SUICIDE, or go to your nearest emergency room if you have these thoughts or intentions.
- If you are in an abusive or violent relationship
- If you have been seriously depressed
- If you have a serious substance abuse dependence

If I believe you are a danger or could become a danger to yourself or someone else, I may inform others or insist that you be evaluated in person by another health care professional.

If you have experienced one or more of the above in the past twelve months, you are encouraged to seek therapy services in an office setting as a more appropriate form of treatment

Procedures Should We Encounter Technical Difficulties or Disruptions in Service:
It is understood that when communicating by internet or other electronic means, disruptions in service or other technical difficulties will likely occur from time to time. Should a disruption occur at a time of crisis, the client agrees to immediately phone me at **832-298-6356** where we can finish the scheduled session time. Payment remains to be full amount if session has met or exceeded 25 minutes. If session is interrupted before the 25 minutes for any given reason and there is no phone contact made to finish the allotted time, the payment will decrease to $65, and both parties agree to fix the technical issue as soon as possible.

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Additional Limits of Confidentiality for Online Therapy

Katie Porter, M.A., LPC has taken all steps necessary to protect the confidentiality of participating members during the video sessions. With that said, there is no 100% guarantee. The following are some examples of an accidental breach:

-Video profiles can be compromised giving third-party access to profile information

-If not logged out properly after each use, user profile can be used by third-party members and can gain private information from this profile

-Misdelivery of video "call" to incorrectly typed username

For these reasons, it is imperative that all direct parties involved agree to, and actively execute the following:

- Client and therapist know the assigned session time and date to log in.
- Client and therapist create new usernames that are only for therapy sessions (not using personal profile username).
- Client and therapist log out immediately after each session is over.
- Client and therapist communicate with one another via phone call if there needs to be a rescheduling or cancellation of a session for any reason, to the point where both parties have acknowledged the session change and agree to the new time, to avoid late cancel or no show fees. Katie Porter, M.A., LPC can be reached at **832-298-6356** in such an event.
- Client and therapist agree to log on for scheduled session five to ten minutes prior to the scheduled time to avoid being late for session.
- Client and therapist participate in the video session in a private area, where therapist and client are alone, such as in an office, or bedroom, etc. - not in a communal room with others present.
- You, the client are encouraged to protect your own confidentiality by controlling access to your communications with me, such as by using passwords only used by you, controlling access to your computer, and deleting data as required.
- Client and therapist in good faith carry out all necessary means of keeping information confidential and secure by HIPAA, Code of Ethics, and lawful standards.

-Both the client and therapist agree to use online therapy for its intended purposes and will not in any way violate one another's boundaries by looking up personal information on the internet, or using any social media interactions. This may be grounds for immediate termination and referrals will be given.

-Therapist shall not be held responsible for any consequential damages, direct or indirect for failure of the client to adhere strictly and agree to all above-stated guidelines, and further shall hold therapist harmless from same.

If you decide to go the route of treatment with online therapy and also qualify for online therapy:

1. I the client agree that I reside in the state of Texas.
2. I the client am aware that a HIPAA Notice of Privacy Practices is available for me to read and has been included in the intake packet.
3. I the client agree to participate in online therapy. I have read, understood, and comply with the above-stated and agreed upon policies. I understand that the fee agreed upon by Katie Porter, M.A., LPC,PLLC and client is due the day of the session paid by credit card.

Client _____ Date_____

If client is a minor:

Client (minor) _____ Date_____

Guardian _____ Date_____

Social Networking/Media – If you choose to participate in the various forms of social networking/media (i.e. Facebook, Twitter, or blog), please understand that your name and/or picture may be visible to others and therefore your identity cannot be protected in these situations. Colleagues, friends and others also participate in these communication tools and

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distinctions are not made about who is a client and who is not. **Choos*ing to participate on any therapist's social media is a risk and not advised.***

I reserve the right to remove any follower's comments or block any individual from participating. In order to preserve our confidentiality and the integrity of our working relationship, I will not accept any invitations via social networking sites, nor will I respond to blogs written by clients or accept comments on my blog from clients.

Consultation - In order to serve you best, I may desire to consult with colleagues or an expert in a particular area relevant to your psychotherapy. I do this without identifying information so that your privacy is protected.

Plan For Practice in Case of Death or Disability- In the event of my death, incapacity or disability, I have made arrangements for another psychologist to take over my practice, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

Privacy Rights - Professional ethics and legal standards require that our conversations and my records (even the fact that you are a client) be kept confidential. However, under the following circumstances**, I am legally and ethically obligated to breach confidentiality: (a) If you present a serious imminent danger or threat to yourself or others (b) in cases of apparent abuse or neglect of a child, an elderly person, or a disabled person (c) when required by legal proceedings.** If I must breach confidentiality, the minimum amount of information will be revealed—only enough to protect you or others.

As a parent or guardian, you will naturally be curious about what happens in counseling sessions with your child. It is important that your child or adolescent feel safe and able to trust the counseling relationship. It is my policy to maintain confidentiality with your child or adolescent while keeping you updated on your child's progress. I ask you to remember that as a professional, if at any time I feel your child or adolescent is in serious danger, I will break confidentiality to share information with you and the proper authorities if necessary in order to keep your child or adolescent safe. I will inform the client before breaking confidentiality if possible.

Finally, if I want to consult with someone about the specifics of your case in order to better coordinate services (i.e. a doctor or family member), I will request that you sign a release of information. Please review the *Policies and Practices to Protect the Privacy of Your Health Information* for a more extensive explanation of your privacy rights.

Complaints – If you have concerns or complaints regarding your treatment, please talk with me first. If there is no resolution there, you may contact:

Texas State Board of Examiners of Professional Counselors:
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

Or call 1-800-942-5540 to request the appropriate form or to obtain more information.

By signing these polices,

(1) I acknowledge receipt of the *Policies and Practices to Protect the Privacy of Your Health Information*,
(2) I understand that the persons conducting business at 2316 Timber Shadows, Suite 202, are all sole practitioners and any legal action taken against one of the persons may not include the others.
(3) I understand and agree to the stated practice polices as listed above and
(5) I give full consent for myself or my minor child, _____,

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to participate in psychotherapy. I certify that I have the legal right to seek and authorize treatment for myself or my minor child.

_____ _____
Client Signature (or parent/guardian if client is a minor) Date

_____ _____
Print Name (Client/Guardian) Date

I have discussed these issues with the client, parent, or guardian of the client, or other representative. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give me informed and willing consent.

_____ _____
Counselor Signature Date

Contractual Agreement for Medical Stability and Health Concerns

_____ I understand that while in outpatient therapy with Katie Porter, M.A., LPC, PLLC, I am agreeing to make active steps towards recovery and work alongside my treatment team to help maintain medical stability.

_____ If my therapist or any member of the treatment team advises me that a higher level of care is needed and/or recommended in order to maintain medical stability or to address other mental health needs, I will cooperate.

_____ I know that this is for my best interest, and will ask any questions to my therapist and treatment team that I may have.

_____ If Katie Porter, M.A., LPC, PLLC or another member of the treatment team advises me to seek additional treatment and I refuse, Katie Porter, M.A., LPC, PLLC has the right to terminate treatment, as per ethical and liable guidelines.

_____ I have had all my questions answered and agree to comply with this agreement.

_____ _____
Client Signature Date

_____ _____
Guardian Signature (if applicable) Date

_____ _____
Therapist Signature Date

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Notice of Privacy Practices

PLEASE KEEP THIS FOR YOUR RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the APA Code of Ethics.

It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment

We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations

We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law

Katie Porter, M.A., LPC, PLLC, CNFC, EMDR and Brainspotting Trained
1525 Lakeville Drive, Suite 217
Kingwood, Texas 77339
Phone: 832-298-6356
Email: k.b.porter@protonmail.com

Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a licensed professional counselor licensed in this state, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization in some cases. The following language addresses these categories to the extent consistent with the APA Code of Ethics and HIPAA.

Child Abuse or Neglect

We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings

We may disclose your PHI pursuant to a subpoena, court order, administrative order or similar process.

Deceased Patients

We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies

We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care

We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm to self or others.

Suicidal and/or Homicidal Emergencies

We may disclose your PHI to the proper authorities in a situation whereupon therapist believes, or has reason to believe that that client could engage in any suicidal or homicidal actions.

Health Oversight

If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent, and peer review organizations performing utilization and quality control.

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Law Enforcement

We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions

We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health

If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, or to a government agency that is collaborating with that public health authority.

Public Safety

We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the
threat.

Research

PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission

We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:(i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please

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submit your request in writing to your Privacy Officer, Katie Porter, MA, LPC at 832-298-6356.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer, Katie Porter, with any questions.

- Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, please speak with your therapist and Privacy Officer, you have the right to file a complaint in writing with our Privacy Officer, Katie Porter, at 1525 Lakeville Drive, Suite 217, Kingwood TX 77339. If there is no resolution with your therapist, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Ave, SW Washington DC 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

Your Privacy Officer and Security Officer is Katie Porter, MA, LPC.

The effective date of this Notice is September 2013.

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RELEASE OF INFORMATION

Client name _____

I understand that my records may be protected by law. If so,

I authorize _____
(person, school, agency, physician, etc.)
at _____
(address, email, or phone number)

and Katie Porter, M.A., LPC, PLLC to exchange information for the purpose of enhancement of treatment. This information is to include medications, behavioral information and impressions, and any other pertinent information. I understand that exchanges may include and are not limited to information pertaining to risk of harm to self or others, history of abuse, mental health diagnoses, medical diagnoses, and substance use or abuse history. I also understand that this consent is revocable at any time with written notice. This signed record of consent is valid in both paper and electronic form (i.e., PDF, scanned, emailed, photo).

_____ _____
Client Signature (parent or guardian if applicable) Date

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Signature Card-MC/VISA/AMEX/DISCOVER

If your card information changes you are responsible for updating the information with your therapist

Name on card _____

Billing address_____

_____

Card #_____

Expiration Date_____ Security Code_____

Cancellation and Missed Appointments - Since scheduling an appointment involves reserving a time specifically for you, a 24-hour advance notice is required for cancellations (except in the case of an emergency). If you cancel less than 24 hours before your appointment, you will be considered a NO SHOW for that visit and you will be charged the FULL FEE for that session. Once you have two NO SHOW appointments, you will be required to secure any subsequent appointments with a credit card. Subsequent NO SHOW appointments will be charged the FULL FEE for the missed session.

Authorized Signature_____

Today's Date_____