Sensory Skills for Eating Disorders, LLC
Initial Paperwork

Informed Consent and Practice Policies for Online Therapy

Welcome! We are pleased that you have chosen us to be your treatment team providers. This document answers many questions clients often ask about treatment, and it explains procedures, financial policies and the privacy policies used in the practice of Sensory Skills for Eating Disorders, LLC. 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 – We believe that treatment is an interactive process between the practitioners 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 treatment process. An effective counseling relationship involves developing a healthy relationship with clear boundaries. We believe that our job as practitioners is to help the client find his/her/their way through what may be difficult times or situations. And although ultimately only the client can direct the path, we are supportive, understanding and caring through the treatment process and regard each client as an individual with individual needs. Please know that we are professionals who are committed to your well-being.

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

In the first session we will discuss your presenting concerns, your history, and the goals you want to accomplish. If we are meeting with a minor, we 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, treatment 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 relationships with family members, spouse, or other significant relationships. If one parent has custody of the minor then documentation identifying the managing conservator will be required before treatment begins.

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. You, the client, are in complete control. We will check in on a monthly basis to confirm that the level and frequency of sessions is supporting your needs. 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 us first with your thoughts, and you may ask for referrals to other therapists.

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 our office, or subpoena us to testify in court or in any legal proceeding. By your signature below, you agree to abide by this agreement.

Initial _____

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

If we are required to testify in court or give a deposition, the hourly fee is $300 per hour per person 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 $300.00 per hour per person for every hour or portion of an hour spent in court or deposition.

When we go to court or give a deposition, we have to clear our schedules 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.

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

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

Court Appearances - Our focus in providing counseling and psychotherapy is on treatment and healing. It is NOT our intention to become involved in cases that require evaluation (either written or otherwise) or in 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 our treatment records or our testimony in court, this will represent a conflict of interest for us, and we will terminate our therapeutic relationship and provide referrals to other providers. This position is based on two main reasons: 1) Our 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 we are required to appear in court or conference via telephone, the CLIENT/GUARDIAN will be REQUIRED to pay the fees listed above.
Initial _____

CANCELLATION AND MISSED APPOINTMENTS

Since scheduling an appointment involves reserving a time specifically for you, 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 _____

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. We must emphasize that we are not crisis counselors. If you would like to communicate your emergency to us, that is fine but we will discuss it during our next scheduled appointment. If we are out of town, we 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 emergency.

Initial _____

TELEHEALTH INFORMED CONSENT

Telehealth involves the use of electronic communications to enable Kathy Gray and Michelle Fee to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. Telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners and others that I have signed releases for communication.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. A copy of our Office Policies and Therapeutic Informed Consent can be provided.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the practitioner, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Sensory Skills for Eating Disorders, LLC utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via Zoom.

4. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy and nutrition services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my practitioner, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Name _____

Client's Signature/Date _____

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 the practitioners at Sensory Skills for Eating Disorders, LLC 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

INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Gender: Male Female Non-Binary Transgender Other:_____

Heights: _____ Weight (if known): _____

Address: _____ City/State/Zip:_____

Employer/School:_____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____

Where do you prefer to receive calls? __Home __Cell __Work Can I leave a message? __Yes __No

May we contact you by e-mail: __Yes __No

Children living in the home:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

If client is a minor:

Mother's Name: _____ Home phone: _____

Work phone: _____ Cell phone: _____

Father's Name: _____ Home phone: _____

Work phone: _____ Cell phone: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone: _____

Health Information

Please list any medical conditions you feel we should be aware of:

_____
_____
_____

Please list the medications and supplements the patient is currently taking, including the dosage:

_____
_____

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

1) 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 obtain more information.

2) Texas Department of Licensing and Regulation, Dietitians

   PO Box 12157

   Austin, Texas 78711

   (800) 803-9202

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: June 1, 2021

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

If you have any questions about this notice, please contact:
Sensory Skills for Eating Disorders, LLC
407 Heights Blvd
Houston, TX 77007
713-622-6422 x1

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

I understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by Sensory Skills for Eating Disorders, LLC.

This Notice will tell you about the ways in which I may use and disclose protected health information about you. I also describe your rights and certain obligations I have regarding the use and disclosure of protected health information. The law requires me to:

- Make sure that protected health information that identifies you is kept private;
- Notify you about how I protect protected health information about you;
- Explain how, when and why I use and disclose protected health information;
- Follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that I maintain by:

- Posting the revised Notice in my office;
- Making copies of the revised Notice available upon request;

HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that I use and disclose protected health information without your written authorization.

For Treatment. I may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. I may disclose protected health information about you to doctors, nurses, technicians, or medical students who are involved in taking care of you.

I may disclose protected health information about you to people outside of my office who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care.

I may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment. I may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.

For Payment for Services. I may use and disclose protected health information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, I may need to give your health plan information about your nutrition services you received so your health plan will pay me or reimburse you for the service. I may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

As Required by Law. I will disclose protected health information about you when required to do so by federal, state or local law.

Research. I may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Health Risks. I may disclose protected health information about you to a government authority if I reasonably believe you are a victim of abuse, neglect or domestic violence. I will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and I believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, I may disclose your information in response to a court or administrative order. I may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by me or the requesting party, to tell you about the request or obtain an order protecting the information requested.

Business Associates. I may disclose information to business associates who perform services on my behalf (such as a billing company); however, I require them to appropriately safeguard your information.

Public Health. As required by law, I may disclose your protected health information to public health or legal authorities charge with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety. I may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Health Oversight Activities. I may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. I may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. I may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

Organ and Tissue Donation. If you are an organ donor, I may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Special Government Functions. If you are a member of the armed forces, I may release protected health information about you if it relates to military and veterans activities. I may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Coroners, Medical Examiners, and Funeral Directors. I may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Correctional Institutions and Other Law Enforcement Custodial Situations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Worker's Compensation. I may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration. I may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

- I may share with a family member, relative, friend or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location, general condition or death.
- I may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, I may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to the contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information I maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Sensory Skills for Eating Disorders, LLC. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other supplies associated with your request, and I will respond to your request no later than 30 days after receiving it. There are certain situations in which I am not required to comply with your request. In these circumstances, I will respond to you in writing, stating why I will not grant your request and describe any rights you may have to request a review of the denial.

Right to Amend. If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted to Sensory Skills for Eating Disorders, LLC. In addition, you must provide a reason that supports your request. I will act on your request for an amendment no later than 60 days after receiving the request.

I may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, I may deny your request if you ask me to amend information that:

- Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Sensory Skills for Eating Disorders, LLC;
- Is not part of the information which you would be permitted to inspect and copy; or
- I believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of protected health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to Sensory Skills for Eating Disorders, LLC. You may ask for disclosures made up to six years before your request. The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I am required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures

- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information I use or disclose about you for treatment, payment or health care operations or to persons involved in your care.

I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described in this document on pages 1-3.

To request restrictions, you must make your request in writing to Sensory Skills for Eating Disorders, LLC.

Right to Request Confidential Communications. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Sensory Skills for Eating Disorders, LLC. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting Sensory Skills for Eating Disorders, LLC.

OTHER USES AND DISCLOSURES

I will obtain your written authorization before using or disclosing your protected health information for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, I will stop using or disclosing your information, except to the extent that I have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Sensory Skills for Eating Disorders, LLC or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint.

If you file a complaint, I will not take any action against you or change your treatment in any way.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Your signature below indicates you have received and agree to the Sensory Skills for Eating Disorders, LLC HIPAA Privacy Notice. (If a patient is a minor, please indicate their name below and sign as parent/legal guardian.)

Client's Name: _____

Client's Signature (or Parent/Guardian Signature if client is a minor): _____

Date: _____