Shonna Porter, LMHC

Revised 3/5/08

# Background Information

**Today's Date _____**

***I. Primary Client Name (If couple, family, or group, the one person who will be the identified client):***

**First Name _____MI_____ Last Name_____M___F___**

**Home Phone # (  ) _____ Work Phone # (  ) _____ Cellular Phone # (  ) _____**

**Address _____City_____State_____Zip_____**

**Mailing address if different from above: _____**

**Drivers license #_____Date of Birth (DOB) _____ SS# _____**

**Employer _____ Client E-mail _____**

***II, Spouses's/Other Client's Information (or if primary client is a minor, give parent/guardian information below):***

***Relationship to primary client: Spouse_____ Parent _____ Legal Guardian _____ Child _____ Other_____***

**First Name _____MI_____Last Name_____M___F___**

**Home Phone # (  )_____ Work Phone# (  )_____ Cellular Phone # (  ) _____**

**Address _____City_____State_____Zip_____**

**Mailing address if different from above: _____**

**Driver's license # _____ Date of Birth (DOB) _____ SS # _____**

**Employer _____ Client E-mail _____**

*If we are billing your insurance please fill out the following information completely:*

**Are you using an Employee Assistance Program (EAP)? _____ yes _____ no If yes, who do we bill? _____**

**EAP Phone# (  )_____ How many sessions? _____ Authorization # _____**

*Primary Ins. Co* _____ *Grp #* _____ *ID#* _____

**Ins. Billing Address _____Ins. Phone # _____**

**City_____State_____Zip_____**

**Name of Subscriber _____ Relationship to client _____**

**Subscriber's Address (if not above)_____ DOB _____**

**City_____State_____Zip_____ SS# _____**

**Subscriber's Employer _____ Phone # _____**

*Any secondary insurance?(please give complete information)*_____

_____

_____

**Signature of person financially responsible for bill: (Include address and Phone # if not above) _____**

_____

**Have you (or any member of your family) previously been a client of Pearl Counseling Associates, LLC? □ Yes □ No**
**If yes, is your (or family members) portion of the account with that counselor clear and/or current? □ Yes □ No**

***PERSON TO NOTIFY IF EMERGENCY:***
**Relative: _____ Phone: (  ) _____**
**Name and address of person, organization, or ad that referred you:**
**_____Phone: (  ) _____**

# Intake Questionnaire

**Shonna Porter, LMHC**

**Name: _____ Date: _____ Email (optional): _____**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
_____Yes _____ No If yes, from whom, where and for how long? _____
_____

Have you had previous psychotherapy? _____ Yes _____No If yes, when? _____
Previous therapist's name: _____
What did you find helpful/not helpful about your previous therapist? _____
_____

Are you currently taking prescribed psychiatric medication (i.e. antidepressants, etc.)? ____ Yes ___ No
If yes, please list: _____
If no, have you previously taken psychiatric medication? _____ Yes _____ No
If yes, please list – Name: _____ Dosage: _____ Duration: _____

Please list any additional supplements or over the counter medications you are taking: _____
_____

**Health and Social Information:**

1. How is your physical health at present?
   _____ Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very Good

2. Please list any previous or current persistent physical symptoms, conditions, surgeries or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
   _____

3. Are you having any problems with your sleep habits? _____Yes _____ No
   If yes, check where applicable:
   _____ Sleeping too little _____Sleeping too much _____ Poor quality sleep _____ Disturbing dreams
   For how long? _____ How often? _____

4. How many times per week do you exercise? _____ For how long each time? _____

5. Are you having any difficulty with appetite or eating habits? _____ Yes _____ No

6. Do you regularly use alcohol? _____ Yes _____ No
   In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. Do you engage in recreational drug use? _____ Yes _____ No If yes, how often?
   _____ Daily _____ Weekly _____ Monthly _____ Rarely

8. Have you had suicidal thoughts recently? ____ Frequently ____ Sometimes ____ Rarely ____ Never
   Have you had them in the past? ____ Frequently ____Sometimes ____Rarely ____ Never

9. Are you currently in a romantic relationship? ____ Yes ____ No
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. Please list your greatest concerns/issues/stressors: _____
_____
_____

Are you currently or have you ever experienced any of the following:

| | | | Approximate date of onset and duration: |
|---|---|---|---|
| Extreme depressed mood: | Y | N | _____ |
| Wild mood swings: | Y | N | _____ |
| Rapid speech: | Y | N | _____ |
| Extreme anxiety: | Y | N | _____ |
| Panic attacks: | Y | N | _____ |
| Phobias: | Y | N | _____ |
| Sleep disturbances: | Y | N | _____ |
| Hallucinations: | Y | N | _____ |
| Unexplained losses of time: | Y | N | _____ |
| Unexplained memory lapses: | Y | N | _____ |
| Alcohol/substance abuse: | Y | N | _____ |
| Frequent body complaints: | Y | N | _____ |
| Eating disorder: | Y | N | _____ |
| Body image problems: | Y | N | _____ |
| Repetitive thoughts (obsessions): | Y | N | _____ |
| Repetitive behaviors (hand-washing): | Y | N | _____ |
| Homicidal thoughts: | Y | N | _____ |
| Suicide attempt: | Y | N | _____ |

**Occupational Information:**

Are you currently employed? _____ Yes _____ No
If yes, who is your current employer/position? _____
If yes, are you happy at your current position? _____
Please list any work-related stressors: _____
_____
_____

**Religious/Spiritual Information:**

Do you attend church regularly? _____ Yes _____ No
If yes, what is your faith? _____
If not do you consider yourself to be spiritual? _____ Yes _____ No

**Family Mental Health History:**

Has anyone in your family (either immediate family members or relatives) experienced difficulty with any of the following? Please check any that apply and who it applies to (e.g. sibling, parent, uncle, etc.):

| **Difficulty** | | **Family Member** |
|---|---|---|
| Depression | _____ | _____ |
| Bipolar Disorder | _____ | _____ |
| Anxiety Disorder | _____ | _____ |
| Panic Attacks | _____ | _____ |
| Schizophrenia | _____ | _____ |
| Alcohol Abuse | _____ | _____ |
| Drug Abuse | _____ | _____ |
| Eating Disorders | _____ | _____ |
| Learning Disability | _____ | _____ |
| Trauma History | _____ | _____ |
| Suicide Attempts | _____ | _____ |

**Other Information:**

What do you consider to be true about you? In summary, who are you? "I am…."

What do you consider to be your greatest strengths? Weaknesses?

What are your greatest personal challenges?

What do you hope to address and accomplish in therapy?

What is the best way I can care for you?

What do you need from a therapist?

PEARL
counseling associates

**Shonna Porter, LMHC**
Individual, Couple & Family Therapy

# Client Information and Disclosure

Shonna@pearlcounseling.com
www.shonnaporter.com

**Training and Degrees**: I received my Bachelor of Arts in Exercise Physiology from Western Washington University in May 1995 and a Masters of Arts in Counseling Psychology from Mars Hill Graduate School in May 2007. I am a trained Lifespan Integration Counselor and a member of the ACA (American Counseling Association). In addition to counseling I am certified through NASM (National Academy of Sports Medicine), ACE (American Council on Exercise) and have been a fitness, health and wellness consultant for over 20 years.

**Counseling Orientation, Techniques and Methods:** My training is primarily Object Relations Therapy, meaning I am a relational therapist who uses relational patterns, attachment patterns, family of origin and emotional relatedness to explore where there may be "dis-ease" in your life. According to my theory many of our deepest issues are rooted in relationship. In addition to Lifespan Integration and talk therapy, I use a variety of other tools depending on the presenting problems and in some cases homework is required. It is also important to note that therapy can be very disrupting and you may feel things are getting worse before they get better. This is very common during the process of change and transformation. However, there are no guarantees regarding the outcome of treatment, desired change and outcomes of therapy are inevitably up to you. Our time together will be 45-55 minutes in length for a general session and 90 minutes in length for Lifespan Integration work or unless otherwise scheduled. Group sessions are typically 90 minutes.

**Billing and Insurance:** I am a Licensed Mental Health Counseling with the state of WA, #LH60498106. I am an in network provider for some insurance plans. Please check with your insurance to determine whether or not I am a preferred provider and what your mental health benefit will be. Should we choose to work together, our first intake session is 45-60 minutes in length and is $150.00. Subsequent sessions will be billed at my standard fee of $110.00 per 45-55-minute session ($165.00 per 90 minute session). If you are not using insurance and agree to make full payment at the time of service, the fee can be discounted to $125 for the intake session and $90 for subsequent sessions.

Payment can be made by credit card (Visa, MasterCard), debit card (Visa, MasterCard), cash, or check. All checks should be made out to **Shonna Porter Counseling**. Fees may increase periodically, and are subject to change with prior notification. I require 24-hours notice if you need to cancel or reschedule an appointment. Should you miss a session or cancel a session without 24-hours notice, you will be billed for that session and are expected to pay for your missed time. (Insurance does not cover missed sessions) If payments or cancellations become problematic you may have the option to pre-pay each session in order to hold your time slot open. Any outstanding monies owed will be sent to a collection agency after 90 days.

**Confidentiality:** There is a legal privilege in the state of Washington protecting the confidentiality of any information you share with me. As a professional I can assure you I strive to maintain the strictest standards of confidentiality. Your information will not be released to outside sources without your written permission unless the law requires me to do so. The only exception to this is if you are planning to harm yourself or someone else. (Detailed information about these exceptions can be read in the Washington Notice Form (HIPPA)).

**Confidentiality and Technology:** Some clients may choose to use technology in our counseling relationship. This includes but is not limited to online counseling via Skype, telephone, email, text. Due to the nature of electronic communication, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur.

Please be advised to take precautions with regard to authorized and unauthorized access to any technology that is used. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology.

**Contacting by phone:** To schedule, reschedule, or cancel an appointment, please utilize my online scheduling tool at http://shonnaportercounseling.fullslate.com. You may also reach me at Pearl Counseling 253-752-1860 x323. I check my messages on a regular basis and will usually return your call within 24-hours on any business day.

**Contacting by email:** I do allow clients to contact me through email at shonna@pearlcounseling.com. However, this is not a forum for discussing serious issues, staying "in touch" through lengthy updates, or for counseling of any sort. Email is for the sole purpose of initial contact, appropriate brief inquiries, or in the event alternative communication is not possible. Should you send me an email, you can expect brief responses from me until we can talk on the phone or at your next session.

**Social Media:** My goal is to protect each client's privacy and autonomy; therefore I do not accept friend requests on social media.

**Scheduling via text:** Once the therapeutic relationship is initiated, texting may become a preferred, or at times a more efficient medium with which to schedule an appointment. Should we agree to this, texts should be brief and professional. Please do not use texting for any other purpose. Once our therapeutic relationship has been terminated, your information will be deleted from any and all technological devices.

**Emergencies:**
In the event of an emergency call 911.
You can also call the Crisis Line in Tacoma at 253-798-4333.
The Domestic Violence Hotline is 1-800-562-6025.

***I have read, understand and agree with all of the information, policies and procedures presented in this form.***

***Client Signature***_____

***Date***_____

***Counselor Signature***_____

***Date***_____

# Financial Policy
## Pearl Counseling Associates, LLC

Thank you for choosing the providers at Pearl Counseling Associates for your mental health care needs. We are committed to your treatment being successful. Financial consideration is an important part of the counseling process. In order for you and your counselor to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment and what this office expects from you.

In order to provide you with the highest quality service while keeping our billing costs low, we offer paperless billing through EASY PAY. We simply maintain your credit or debit card number on file to satisfy all fees charged including late cancels and no shows and, if using insurance, co pays, deductibles, coinsurances and other balances not covered by your insurance. Our Accounts Manager will be more than happy to give you more information about EASY PAY.

**All non-insurance clients are required to pay their full fee at the time of service unless other arrangements have been made**. These arrangements will be done through the Accounts Manager or your counselor by your second visit and must be in writing to be valid. If at any time you pay more than is owed, you may choose either to receive a refund from your counselor or use the credit towards future sessions.

WE ACCEPT as payment, Visa/MasterCard, Debit Cards, Checks, Money Orders and Cash. **Please make checks or money orders payable to YOUR COUNSELOR, not Pearl Counseling Associates, LLC**. (If you use an online banking service to make payment make sure the merchant is your counselor and not Pearl Counseling, LLC.) Any check returned to your counselor for non-sufficient funds (NSF) will be charged back to your account along with an additional $18.00 service charge.

**If you are a non-insurance client you may skip this next session and go to page 2 and begin again at "Divorce Decrees."**

### INSURANCE & INSURANCE COLLECTION

Our Accounts Manager will work very hard to make sure your paperwork is filed accurately and promptly. Nevertheless, please understand that insurance reimbursement can be a long and difficult process. In fact, insurers will routinely stall, deny, and reduce payments. Depending on the type, insurances doing business in the state of Washington have 30 to 90 days to pay or deny a claim. However, even though our Accounts Manager has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which they pay, there may be instances in which we haven't received a payment or denial from the insurance company within the appropriate time. In this case, you then become responsible for paying the account in full if we have not received payment within 90 days.

In the case where you have paid your account in full and insurance pays at a later date or you pay more than is owed, you may choose to receive a refund from your counselor or apply the credit toward any future sessions.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions please call your insurance company and inquire. Your counselor or the Accounts Manager will help you in any way they can if you have problems deciphering the information you receive from your carrier.

You should also be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands we have no control over what they do with it.

**For each client choosing to have a claim submitted to insurance we need the Intake form filled out completely (for both primary & secondary insurances) and making sure the 'Authorization for Use or Disclosure of Protected Health Information for Insurance Claims Processing' form is signed and that we have a copy of your insurance card. We cannot file a claim on your behalf without this release signed.**

As a courtesy, we will bill your insurance for you. For all plans, co-pays, if applicable, must be paid **each and every visit**. There can be no exceptions due to contracting and uniform compliance rules. **You are also responsible for getting proper referral information in advance of your appointment.** Please contact your insurance and ask for your outpatient mental health benefits to see if this applies to you. If you have a **PPO** plan and your counselor is contracted with them, we have agreed to accept the discounted rate from your plan. If you have a coinsurance rather than or in addition to a co-pay you will be billed for these amounts after we have received an explanation of benefits from your insurer. For **Non-Contracted** plans we also expect deductibles, coinsurances, and/or co-pays to be paid at the time of service. Some Non contracted insurance companies may reimburse you for the services rather than us. You are required to pay us in full at the time of service. If you have not done so, and we receive notice from the insurance company that you've been paid, you are expected to pass that amount on to us in addition to the additional amount you owe. For **Non-Contracted plans we also reserve the right to not bill your insurance**. You will be informed of this at the beginning of your counseling. In this case you will receive the necessary paper work for you to get reimbursement from your insurance company and will be required to pay in full at the time of service.

**If you want us to bill insurance for you, make sure you give us all information for all insurances in a timely manner as we will not bill any insurance for dates of service older than 90 days unless obligated to do so under contract.**

**Secondary Insurers:**
Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balance after your insurance(s) has cleared. The above rules for primary insurances apply accordingly to secondary insurances.

**Late to an Appointment:**
If you are using insurance and are late for an appointment, we can only bill insurance for the time that you are actually seen; therefore, you are responsible for the "late" time. (Ex. If you show up more than 20 min. late for an appointment – we will bill your insurance for half and you for half). By signing this policy you agree to waive your rights of health care coverage under your benefits and make complete payment for your portion of the service you were late.

**Hold Harmless:**
Your counselor may perform, with your consent, procedures that are not covered under your insurance policy. These may include marital, family, and/or sexual counseling as well as behavioral disorders and others. Furthermore, you may have obtained services that have not received the proper preauthorization for the date of service rendered. By signing this policy you agree to waive your rights of health care coverage under your benefits and make complete payment for these services rendered to the extent that any contracts will allow.

**Usual & Customary Rates:**
Our practice is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary fees. This applies to non-participating plans only.

**Divorce Decrees:**
This office is NOT a party to your divorce decree. Adult clients are responsible for their portion of the bill at the time of service. The responsibility for minors rests with the accompanying adult. (See below for



Intials _____

additional details.) An exception may be made if we have a written authorization from a third party, prior to the start of counseling, indicating that they will be responsible for fees billed to them.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. (If the minor is covered by insurance the policies applicable to their type of insurance apply.) For unaccompanied minors, non-emergency treatment will be denied unless charges have been authorized to a Visa/MasterCard/Bank Card, payment by cash or check at time of service has been verified, or we have the signature on file of the person(s) financially responsible for the bill on record and they have read and signed this policy.

**Collections and Rebilling Fees:**

While it is never our preferred choice, it may become necessary to send an account to collections. You are responsible for all collection fees. An initial fee of $30.00 will be added to your account to start the collections process.

We are not a billing company. We may charge a rebilling fee of $10.00 per bill on past due accounts (over 30 days).

If you do not follow through on payment arrangements or if your account is sent to collections and you are an active client, non-emergency counseling sessions will be suspended until such time as your account is brought up to date and paid in full.

If you are a returning client that has previously been seen by a counselor at Pearl Counseling Associates, LLC and was at any time sent to collections, you will first be required to have your account clear with the collection agency (or us) and then be required to pay your counselor in full with cash or money order at the time of service. The exception is, if you have insurance that your counselor is contracted with (preferred provider), we will continue to bill the insurance for you and you will be required to pay any co-pays, with cash or money order at the time of service. (If your counselor is a non-contracted provider with your insurance company you will pay in full and, as a courtesy, we may bill your insurance for you. Any insurance payments that may come to us will be refunded to you or applied to future sessions per your instructions.) If at any time payment is not made at the time of service you will not be allowed to reschedule until your account is paid and current.

**On Call Counseling**

Sometimes it is necessary for clients to see an "on call" counselor at Pearl Counseling Associates, LLC because their counselor is not available and crisis or emergency counseling is needed during their counselor's absence. If you need the services of an "on call" counselor, it is your responsibility to pay the "on call" counselor at the time of service. The charge will be at the "on call" counselor's rate. **Insurance will not be billed for these sessions. Exception:** If the "on call" counselor is a preferred provider for your insurance and you wish to bill the insurance then you will need to intake with the "on call" counselor as if you are a new client.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

**I have read the Financial Policy. I understand and agree to this Financial Policy:**

**X _____ Date_____**
**Signature of Patient or Responsible Party**

**X _____ Date_____**
**Signature of Co-Responsible Party**

# Notice of Privacy Practices

**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. State and federal law protects the confidentiality of this information. "Protected Health Information," (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Your Rights Regarding Your PHI**

You have the following rights regarding your PHI that I maintain about you:

***Right of Access to Inspect and Copy.*** You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

***Right to Amend.*** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

***Right to an Accounting of Disclosures.*** You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

***Right to Request Confidential Communication.*** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

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

***Right of Complaint.*** You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

**MY USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION**

***Treatment.*** Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.



Initials _____

***Payment.*** I will not use your PHI to obtain payment for your health care services without your written 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.

***Healthcare Operations.*** I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health related products or services that may be of interest to you.

**OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT**

***Required by Law.*** I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

***Health Oversight.*** I may disclose PHI to a health oversight agency for activities authorized by law such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third party payers).

***Abuse or Neglect.*** I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

***Research.*** I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

***Threat to Health or Safety.*** I may disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of the public or another person.

***Criminal Activity on My Business Premises/Against My Staff or Me.*** I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against my staff or me.

***Compulsory Process.*** I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.



Initials_____

**USES AND DISCLOSURES OF PHI WITH YOUR WRITTEN AUTHORIZATION**

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

**THIS NOTICE**

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your right regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *Notice of Privacy Practices* at any time. Any new *Notice of Privacy Practices* will be effective for all PHI that I maintain at that time. I will make available a revised *Notice of Privacy Practices* by sending a copy to you in the mail upon request, or providing one to you at your next appointment.

**CONTACT INFORMATION**

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is:

Shonna Porter, MA
1919 N Pearl St., Ste. C-1
Tacoma WA 98406
(253) 752-1860x323

**COMPLAINTS**

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this *Notice*. I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this notice is April 14, 2003

**ACKNOWLEDGMENT**

I hereby acknowledge receiving a copy of this notice.

*Client's Signature* *Date*

*Client's Signature* *Date*

**Shonna Porter, LMHC**
Pearl Counseling Associates
1919 N Pearl St., Ste. C-1, Tacoma WA 98406
Office: (253) 752-1860 x **323**, FAX: (253) 752-1890

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR INSURANCE CLAIMS PROCESSING

## TYPE OF INFORMATION TO BE DISCLOSED

I hereby authorize **Shonna Porter and/or his billing representative** to use and/or disclose the following protected health information: **Please initial.**

- ❑ _____ Information required to process manual claims
- ❑ _____ Information required to process electronic claims

## ASSIGNMENT OF BENEFITS (Please initial)

- ❑ _____ I authorize my insurance benefits to be paid directly to the provider.

## INSURANCE COMPANY TO WHICH PROTECTED HEALTH INFORMATION WILL GO

Name_____

Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

## REVOCATION AND REDISCLOSURE

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized re-disclosure by recipient is a potential risk.

## DURATION

If not previously revoked, this authorization will expire one (1) year from date signed below.

***Specific Limitation**:* Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

## SIGNATURE

This Authorization covers protected health information pertaining to *(client)* _____.
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the Date of that signature (initial or renewal). I acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third party involvement.

Signature: _____ Date: _____

Patient/Parent/Guardian/Other legal representative for health care decisions: _____

Renewal Signature: _____ Date: _____

Witness: _____ Date: _____