KATHERINE M KILGORE, PHD
CLINICAL PSYCHOLOGIST
LIC # PSY 14094

_____/_____/_____ _____ _____
DATE NAME AGE

_____
STREET CITY ZIP

_____ _____ _____/_____/_____
MOBILE PHONE EMAIL DATE OF BIRTH

_____ _____
SOCIAL SECURITY # (REQUIRED) MARITAL STATUS

_____ _____
EMPLOYER OCCUPATION

_____ _____
PRIMARY CARE PHYSICIAN SPECIALIST PHYSICIAN

_____ _____
INSURANCE COMPANY WHO REFERRED YOU TO THIS OFFICE?
Note: You are responsible for the entire fee. Without prior authorization your carrier may refuse reimbursement.

_____ _____
NAME OF INSURED RELATIONSHIP TO PATIENT

_____ _____ _____
PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP TO PATIENT PHONE
(If in the case of an emergency it becomes necessary to contact this individual, only that information required to keep you safe will be released.)

I assign all medical benefits to which I am entitled, including private insurance and other health plans, to Katherine M Kilgore, PhD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that payment in full is expected at the time of service, and that I am responsible for all charges regardless of insurance coverage. I authorize the release of all information necessary to process claims. I also give my consent for Dr. Kilgore to release all required billing information to any provider I may contact while that provider is taking calls for Dr. Kilgore. In the event that I pay for services via approved credit card charges, I agree that no dispute with Katherine M Kilgore, PhD will be raised with, or adjudicated by, the credit card company. I acknowledge that credit card payments are non-refundable by or through the credit card company.

I give Dr. Kilgore consent to contact my physician as necessary to inform her/him of my treatment and progress.

_____ _____
PATIENT OR AUTHORIZED PERSON/GUARDIAN DATE

Katherine M Kilgore, PhD
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LIC # 14094

I, _____, am authorizing Katherine M Kilgore, PhD to charge my credit card as payment for services provided. She may also charge fees incurred in the event that I do not notify her of my inability to attend a scheduled therapy appointment and/or do not cancel my appointment at least 24 hours in advance, as agreed to in the signed Office Policy/Informed Consent.

Card Type (circle one):

Visa MasterCard Debit

_____ _____
CARD # EXPIRATION DATE

_____ _____
NAME ON CARD VERIFICATION/SECURITY CODE
(3-DIGIT CODE ON BACK OF CARD)

_____
BILLING ADDRESS

_____
CITY STATE ZIP

_____ _____
SIGNATURE DATE

Personal History

_____ _____

Name Date

Gender: _____ Pronouns: _____

Can you briefly describe the current concerns or problems that you want to work on?

_____

_____

_____

What caused you to decide to call at this time, rather than last week or next month?

_____

_____

What are your goals for treatment?

_____

_____

What is your general medical history, e.g., serious illnesses, accidents, injuries, operations?

_____ Date: _____

_____ Date: _____

_____ Date: _____

How is your general health today? ___ Excellent ___ Good ___ Fair ___ Poor

Have you ever had any head injuries, been knocked unconscious, or had a seizure? ___ Y ___ N

Current medications: Prescribing doctor

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

_____ ___mg 1/day 2/day 3/day 4/day _____

Have you had any previous psychological therapy? When and with whom?

_____

_____

Have any of your family members been treated for a psychological complaint?

_____

What is your current use of alcohol, drugs, and tobacco? Have you ever had problems with them?

_____

What is your family's history of alcohol, drug, and tobacco use/abuse?

_____

With whom do you currently live?

_____

Military history:

_____

What is your marital/significant other history:

#1 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

#2 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

#3 Name: _____ From: _____To: _____

Reason for ending:_____ Children: _____

Mother living? [ ]Y [ ] N Age: ___ Year of death: _____ Cause of death: _____

Father living? [ ]Y [ ] N Age: ___ Year of death: _____ Cause of death: _____

Are your parents married? [ ]Y [ ] N Divorce date: _____ Your age at time of divorce: _____

Who are your sisters and brothers?

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

What is the quality of your relationships with your family members?

_____

Where were you born and raised?

_____

Did you graduate high school? [ ]Y [ ] N Year: _____ Receive a G.E.D.? Year _____

Did you attend trade school? [ ]Y [ ] N Year: _____ Degree/certificate: _____

Did you attend college? [ ]Y [ ] N Did you graduate? [ ]Y [ ] N Year: _____ Degree: _____

What is your work history over the past several years?

_____ From: _____ To: _____

_____ From: _____ To: _____

_____ From: _____ To: _____

Have you ever been suspended [ ] expelled from school [ ] arrested [ ] sued [ ] had legal trouble [ ] initiated a lawsuit [ ] been fired [ ] suspended from work [ ]

Have you ever been abused physically [ ] sexually [ ] emotionally [ ]

Details of any of the above:

_____

_____

_____

Name _____ Date _____

If present, please indicate by letter how long you have been experiencing any of these symptoms:
Days **W**eeks **M**onths **Y**ears

A.
___ Acting out of character
___ Difficult to remain awake or alert
___ Difficult to express myself
___ Difficult to move easily
___ Mind wandering
___ Staring often
___ Difficult to focus on one task
___ Mood is depressed, angry, or irritable
___ Dress or grooming has changed lately
___ Trouble going to sleep
___ Trouble staying asleep &/or waking early
___ Sleeping too much
___ Needing very little sleep
___ Feeling guilty
___ Feeling more depressed in the morning
___ Thoughts of suicide
___ Have made suicide attempts
___ Fatigue, loss of energy
___ Mood euphoric or manic
___ Poor concentration
___ Spending lots of money
___ Full of great ideas of how to make money
___ Feeling especially sexual, excited
___ Easily distracted, poor attention
___ Changes in memory
___ Decreased sexual appetite
___ Restlessness, can't relax
___ Loss of pleasure in usual activities
___ Reduced appetite
___ Increased appetite
___ Noticeable weight change up __ down __
___ Feeling worthless
___ Feeling sad
___ Withdrawing from others
___ Being more active than usual
___ Talking in circles, can't stay on topic
___ Confusion
___ Crying easily for almost no reason
___ Emotionally sensitive, easily hurt

B.
___ Rapid or pounding heart
___ Dizziness/lightheadedness
___ Cold, clammy hands
___ Numbness/tingling in arms, hands, legs
___ Unusual sweating
___ Sense of dread
___ Frequent urination
___ Panic or terror for no apparent reason
___ High anxiety
___ Trembling
___ Fear of losing control
___ Avoidance of certain situations
___ Sense that I am not real
___ Sense that the world is different or not real

C.
___ Nausea, upset stomach, ulcers
___ Headaches
___ Lower back pain
___ Vomiting
___ High blood pressure
___ Menstrual irregularities
___ Asthma
___ Irritable bowels
___ Constipation
___ Diarrhea
___ Use of street drugs, excessive alcohol
___ Eating disturbance/over focusing on food
___ Thyroid dysfunction
___ Diabetes or hypoglycemia
___ Heart disease

D.
___ Tics or motor "habits"
___ Intrusive or unwanted thoughts
___ Rituals that must be performed
___ Checking
___ Counting
___ Need for symmetry, having things "just so"
___ Excessive washing or cleaning
___ Uncontrollable habits or behaviors
___ Sense of constant internal pressure or drive

E.
___ Asking the same questions repeatedly
___ Forgetting how to do basic tasks
___ Problems paying bills/balancing checkbook
___ Getting lost in familiar places.
___ Being told you are neglecting personal hygiene
___ Relying on someone else to make decisions
___ Argue with others over small things
___ Feel that people don't like you
___ Want to be alone more than with others
___ Difficulty communicating with others
___ Feel inadequate, less than others

KATHERINE M KILGORE, PHD
CLINICAL PSYCHOLOGIST
LIC # 14094

I have read the Office Policies and HIPPA Notice of Privacy Practices for psychotherapy services. I understand and agree to the conditions under which Dr. Kilgore and I will work including that she may contact someone to help if I am unable to take adequate care of myself. I am aware that email and cell phone voice mail are not guaranteed to be secure and private. I agree, in the case of a dispute, to use mediation and will not begin a litigated case.

I understand that in the case of my death I have to option to have my complete file destroyed, or I can appoint someone as my representative and custodian of my record.

____ Destroy my file

____ I appoint _____ as custodian.

_____
Phone/email

My signature indicates my understanding of and agreement with all of the Office Policy terms and conditions.

_____ _____
Signature Date

_____
Print name

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CONSENT TO PARTICIPATE IN TELETHERAPY TREATMENT

NATURE OF TELETHERAPY TREATMENT

Teletherapy is psychotherapeutic consultation with Katherine M Kilgore, PhD, a clinical psychologist, via videoconference technology. This means that information related to my mental health is electronically transmitted in the form of images, audio, and data through an interactive video connection to and from Dr. Kilgore. I acknowledge that such electronic transmission of data carries the possibility of interception, corruption, or misdirection. I acknowledge that I am using my own equipment to communicate and not equipment owned by another person, and specifically not using my employer's computer or network. I have been supplied, have read, understand, and agree to, all the terms and conditions regarding teletherapy services provided by Dr. Kilgore.

RISKS, BENEFITS AND ALTERNATIVES

The benefits of teletherapy include having access to Dr. Kilgore's psychotherapy services without having to travel outside of my local health care community. A potential risk of teletherapy is that because of my specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to teletherapy consultation is a face-to-face visit with Dr. Kilgore.

MEDICAL INFORMATION AND RECORDS

All laws concerning patient access to medical records and copies of medical records apply to teletherapy. Dissemination of any patient identifiable images or information from the teletherapy consultation other entities shall not occur without your consent.

RIGHTS

I understand I may withhold or withdraw my consent to a teletherapy session at any time before and/or during the session without affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
I am a citizen of California. I voluntarily agree to participate in teletherapy as described above and explained by Dr. Kilgore. I have read this document and understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

These are the names and telephone numbers of my local emergency contacts.

_____	_____	_____
Police	Phone	Email
_____	_____	_____
Primacy Care Physician	Phone	Email
_____	_____	_____
Local Emergency Contact	Phone	Email

_____	_____
Signature	Date
_____	_____
Printed name	Birth date

KATHERINE M KILGORE, PHD
CLINICAL PSYCHOLOGIST
LIC # 14094

OFFICE POLICIES AND GENERAL INFORMATION

THE PROCESS OF THERAPY

Participation in therapy is voluntary. It can result in a number of benefits to you such as reducing emotional distress, improving interpersonal relationships, and resolving the concerns that led you to seek therapy. Remembering or talking about unpleasant events may bring up feelings or thoughts that can result in considerable discomfort. I will challenge your assumptions and perceptions, and propose different ways of looking at, thinking about, and handling circumstances. This may cause you to feel uneasy, angry, depressed, or disappointed. You may experience anxiety, depression, insomnia, or other conditions. You may decide that changing behaviors, employment, substance use, schooling, housing, or relationships is not appropriate. Sometimes, others may view as a negative decisions you understand to be positive for you. Working toward what you determine to be beneficial requires effort, active involvement, honesty, and openness in order to change your thoughts, feelings, and behaviors. Change may be easy and swift, but more often it will be slow, and can be frustrating. There is no guarantee that therapy will yield the intended results. We will work together to create a plan to accomplish your goals.

You have the right to ask and have explained to you other available treatments for your condition, as well as their risks and benefits. You have the right to not answer any question you wish and no action will be taken against you. Be aware, however, that diagnosis depends on information, and treatment depends on diagnosis, so if you withhold information, you assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, your treatment might be less successful than it otherwise would be, or it could fail completely. If at any time you want another professional opinion or wish to consult another therapist, I can assist you in finding a qualified person.

You have the right to terminate or refuse therapy at any time. If you could benefit from a treatment that I do not provide, or if I determine I am not effective in helping you, I will assist you in obtaining appropriate treatment.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You will benefit from considering this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so it behooves you to be very careful about the therapist you select. If you have questions about my procedures, we may discuss them whenever they arise.

SERVICES PROVIDED:

My practice as a psychologist involves providing psychotherapy to individuals and couples. I will not provide forensic determinations or evaluations. Therapy is most often done in person in my office or via secure online videoconferencing (Zoom). Generally, I do not work with clients younger than 18 years-old. Part of therapy involves various methods of gathering information, including but not limited to psychological testing. This type of assessment is intended to broaden the database specific to you, and to aid in treatment planning. This information may be shared with other treating professionals with your written consent.

CONFIDENTIALITY: *Please refer to the Notice of Privacy Practices*

All information disclosed within our sessions, and the records pertaining to those sessions, is confidential. It will not be revealed to anyone without your written permission, except where disclosure is required by law. None of the information shared in our sessions will be disclosed to anyone outside the psychotherapeutic relationship except for specific situations as described below. In the state of California, except for the following situations, generally you are the only one who can decide what information is shared, with whom, and when. When a situation arises in which confidentiality becomes an issue, I will discuss it with you.

- As a mandated reporter, I must report suspected child abuse. Child abuse includes physical, emotional, and sexual abuse. Sexual abuse is defined as sexual assault, or sexual exploitation that includes downloading, streaming, or accessing through electronic or digital media, material in which a child is engaged in an obscene sexual act.
- In the case of a minor (under the age of 18) the guardian/s hold the privilege, and decide what information can be shared and under which circumstances. The guardian/s can authorize disclosure over the protest of the minor.
- I am required to disclose confidential information that includes, but is not limited to elder (age 65 and over), or dependent adult (disabled, regardless of age) abuse or neglect; threat of harm to self or others; or threat to property or finances.
- In couples, or family therapy, or when different family members are seen individually, confidentiality and privilege may not apply among those involved. I will use my clinical judgment when revealing such information. I will not act as a conduit between the parties. I will not release records to any outside party unless authorized by all adult family members who were party to the treatment.
- By requesting insurance coverage or reimbursement, you waive your confidentiality. The insurance carrier might request treatment information about you. In such case, I will communicate only the necessary minimum information to the carrier. I have no control or knowledge over what happens to this information once it is submitted. Please be aware that submitting a mental health invoice carries a certain amount of risk to confidentiality and privacy.
- I might be required to disclose information if you place your mental status at issue in litigation initiated by you. The defendant may have the right to obtain my psychotherapy records and/or testimony.
- Unauthorized people can intercept email messages, cell phone calls, texts, and faxes. Video conferencing is also open to possible interception.
- I regularly consult with other professional regarding my clients. A client's identity remains completely anonymous and confidentiality is fully maintained.
- There is no privilege when either the psychotherapist or patient alleges a breach of duty arising out of the therapeutic relationship (Evidence Code 1020). This could happen if I need to use a collection agency, e.g.

You have the right to invite any additional parties to your therapy sessions. If you choose to do so the limits of confidentiality are automatically compromised. I will not divulge confidential information to the third party without your consent. Verbal consent during a session is sufficient. The third party does not legally have the same privilege to confidentiality, though I will afford to them the same degree of privacy as I do you. They will not receive a diagnosis, and there will be no individualized treatment plan for them.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. Because these are professional records, they can be misinterpreted and/or be upsetting to untrained readers. You have a right to know what this record contains. I will provide you with a treatment summary unless I believe that to do so would be emotionally damaging. If you wish to see your records, I will review them with you to discuss the contents. Be aware that this will be treated in the same manner as any other professional service and you will be billed accordingly.

APPOINTMENTS AND CANCELLATIONS:

The therapy session, whether in person or online, lasts 55 minutes. You may schedule shorter or extended sessions as necessary. Except for unavoidable emergencies, appointments canceled with less than 24 hours notice will be charged the full fee. Likewise, if you come to the session late you will be charged the full fee. Most insurance policies do not cover a charge for missed sessions. I will contact you as soon as possible if I need to change a scheduled appointment, and you will receive advance notice of my vacations or anticipated time away from the office. There are occasions when the session before yours runs long. I will make adjustments to your fee or schedule accordingly.

You should call 911 or 988 if you are in a medical or emotional crisis, or have an emergent situation that demands immediate attention in order for you to remain safe. You can call me also, and leave a message, indicating that it is important that I call you right away. I will return your call as soon as I can, however, if you

are in crisis it would be better not to wait. Be advised that there is usually a charge for after-hours calls.

PAYMENT:

Depending on your insurance or agreement with me payment, or co-payment, in full is expected at the time of service. I accept cash, check, Venmo, MasterCard, Visa, and HSA. There are benefits to you for paying out of pocket for therapy. First, it protects your confidentiality. As indicated above, many insurers require more than the date of service and diagnostic procedure codes. Some require clinical details with descriptions of symptoms, psychosocial history, family life, social life, and work life, as well as details about treatment strategies and prognosis. I have no knowledge of who might have access to this information, or how it is protected once it leaves my office.

Second, private pay allows you and I to maintain control of your treatment. Insurance companies make decisions about whether treatment or evaluations will be paid for and if so, for how long it should continue. Marital therapy, educational or vocational evaluations, and consults with parents or spouses are routinely disallowed.

Third, not utilizing insurance allows me to avoid providing a psychiatric diagnosis. In nearly all cases, insurance companies pay only for medically necessary treatment, and require a diagnosis of mental illness. These diagnoses can haunt people, affecting hiring decisions or employment advances, raising the cost or precluding the purchase of life or disability insurance, preventing security clearances and the like.

In addition to office and teletherapy visits, services such as telephone conversations, report/record reading and writing, consultation with other professionals, release of information, travel time, etc. may be charged at my hourly rate unless otherwise arrangements have been agreed to. If I am not contracted with your insurance plan you will receive documentation necessary for you to obtain reimbursement of fees paid. Insurance companies do not cover all problems that are the focus of psychotherapy. It is your responsibility to verify the specifics of your coverage.

You are responsible for all charges regardless of coverage. These rates may change without notice. It is agreed that in the event that you pay for services via approved credit card charges, that no dispute with Katherine M Kilgore, PhD will be raised with, or adjudicated by, the credit card company. This means that credit card payments are non-refundable by or through the credit card company. A photo ID is required to protect your identity.

CONTACTING ME and IMMEDIATE CARE:

If you need to contact me between sessions, the best way to do so is by email for administrative issues such as changing appointment times. My email is *Katherine@DrKKilgore.com*.

I prefer using email on a limited basis. It is sufficient to confirm or change appointments, share additional information such as letters or messages sent to your physician, etc. I will use encryption and passwords to protect your information. Email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that I will print and keep in your treatment record, any email I receive from you and any responses that I send to you.

I am often not immediately available by telephone. While I am usually in my office between 9 am and 5 pm, Monday through Friday, I will not answer the phone when I am with a patient. When I am unavailable, voice mail will record your message. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact.

DISPUTES:

It is agreed that should there be legal proceedings (such as, but not limited to, divorce or custody disputes, injuries, lawsuits, etc.), neither you, your attorney, nor anyone acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. In the event this is unavoidable, understand that my fees for such services are double that for therapy.

I share my office space with other therapists. We each practice independently, and do not work under a partnership agreement. Each of us is responsible for conducting her/his practice ethically and morally. We do not treat each other's clients, nor oversee the operating actions of the other therapists.

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by mutual agreement. The cost of mediation, if any, shall be split equally. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement would be submitted to and settled by binding arbitration in Sacramento County in accordance with the rules of the American Arbitration Associations that are in effect at the time the demand for arbitration is filed. The prevailing party in arbitration shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine that sum. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment.

Teletherapy

If you decide to participate in therapy via online videoconferencing technology, there are additional important points and conditions of which you need be aware.

- Understand that online sessions may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the session, that the transmitted information will be unclear or inadequate for proper use in the session, and that it may be possible for an unauthorized person or persons to intercept the information.
- Understand that regardless of what form of communication you use in working with me, confidentiality limits explained above are in effect.
- Note that the teletherapy does not necessarily eliminate your need to see a specialist in person.
- Teletherapy sessions will not be recorded and stored electronically as part of your medical records. Just as with office sessions, I will keep therapeutic notes of our sessions, copies of letters, reports, emails, phone messages, and faxes.
- You will agree not to record the video sessions. You may make notes of the sessions if you wish.
- You agree to unconditionally release and discharge Zoom.com, its affiliates, agents, employees; Katherine M Kilgore, PhD, Inc., its affiliates, agents, and employees; me and my designees from any liability in connection with my participation in the remote consultation(s) as an avenue of treatment.
- You will be asked to provide me with the names and contact numbers for your local First Responders, physician, and emergency contact (friend, family member).

My Social Media Policy

LOCATION-BASED SERVICES:

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites, however, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

I do not accept friend requests from current or former clients on any social networking site. This would compromise your confidentiality and our respective privacy, and blur the boundaries of our therapeutic relationship. I do have a professional page where I submit posts: www.Facebook.com/Dr.KatherineKilgore.

I do not search for clients on Google, Facebook, or other sites. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

You may find my psychology practice on sites such as Yelp, Healthgrades, or other places which list businesses.

Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is not a request for a testimonial, rating, or endorsement from you as my client. The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials.

Of course, you have a right to express yourself on any site you wish. But, due to confidentiality, I will not respond to any review on any of these sites, whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. Please also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. The Confidentiality limitation means that I cannot tell people that you are my client, and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I am your therapist, and how you feel about the treatment I provide you, in any forum of your choosing.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Psychology, which oversees licensing, and they will review the services I have provided.

Board of Psychology
1422 Howe Avenue, Suite 220
Sacramento, CA 95825
866-503-3221

BOPMAIL@DCA.CA.GOV

KATHERINE M KILGORE, PHD
CLINICAL PSYCHOLOGIST
LIC # 14094

Privacy Official – Katherine M Kilgore, PhD

Notice of Privacy Practices

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

I understand that medical information about you and your health is personal. I am committed to protecting your medical information. I create a record of the care and services you receive at my office. I need this record to provide you with quality care and to comply with legal requirements. I am required by law to maintain the privacy of your medical information and to provide you with notice of my legal duties and privacy practices with respect to your medical information. This notice applies to all of the records of your care generated at my office, whether made by myself or by another therapist under my supervision. Health care professionals outside of this office may have different policies.

Your health record is hand-written on paper. There is no digital copy of our sessions. Your medical information may be accessed only by myself or a designated psychologist in the even of my incapacitation, or with your written consent.

I am required to provide you with this Notice about my privacy procedures. This Notice explains when, why, and how I would use and/or disclose your Personal Health Information (PHI). Use of PHI refers to when I share, apply, utilize, examine, or analyze information within my practice. PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law.

I. WHO WILL FOLLOW THIS NOTICE

This notice describes my privacy practices and those of:

- Any health care professional authorized to enter information into your medical records.
- Other health care professionals who provide you with medical care in my facility.

All entities and health care providers described in this notice may share your medical information with each other, as necessary to carry out their treatment, payment, and administrative operations.

II. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. **Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business

associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. **Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information
to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the
interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations. 18. If disclosure is otherwise specifically required by law.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections A, B, and C above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any

future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. **The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. **The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. **The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and HIPAA, Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Katherine M Kilgore, PhD 13405 Folsom Blvd, Suite 220, Folsom, CA 95630. 916 458-5505. katherine@drkkilgore.com.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003.
Privacy Official – Katherine M Kilgore, PhD