DISCLOSURE STATEMENT

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Independent Practice

I am an independently contracted provider participating in the Mindful Therapy Group Organized Health Care Arrangement (OHCA). While I have engaged Mindful Therapy Group, P.C., a Washington Professional Services Corporation (Mindful Therapy Group), to provide business administrative services to my behavioral healthcare business, all services you receive from me reflect my own health care license, independent business, and practice style. Mindful Therapy Group subcontracts with an affiliate company, Mindful Support Services, LLC (Mindful Support Services), to provide a portion of the administrative services.

My License(s), Education and Training

I hold the following license(s) in the indicated state(s):

- Licensed Mental Health Counselor Associate (LMHCA) – License Number: MC61365470

I obtained my Master's Degree in Psychology from Capella University. This educational background has provided me with a solid legal, ethical, and professional foundation essential for practicing mental health counseling. I consistently adhere to the legal and ethical standards established by the State of Washington and federal regulations. Furthermore, I uphold the code of ethics set forth by the American Counseling Association (ACA). In alignment with my commitment to professional development, I complete a minimum of 36 hours of approved continuing education in the mental health field annually.

In my role as an Associate Counselor, I am supervised by a state-approved supervisor. My supervisor and their licensing information is:

Jennifer Trefonas, LMHC (LH00006947)

For more information about my licensure, please visit the Washington State Department of Health.

Patient Mix

I provide therapy services for individuals, couples, and families, accepting clients aged 18 and older. I also offer case management services, which may encompass assistance with paperwork related to disability, unemployment, custody, adoption, foster care, auto accidents, and other legal matters, contingent upon prior discussion and arrangement. Furthermore, I am equipped to work with clients who are court-mandated for

treatment, provided that their needs align with my specialties and areas of practice. Any requirement for disclosure of appointments to external parties will be addressed during the treatment planning process.

Treatment Modality and Therapeutic Orientation

Therapy presents both advantages and challenges. Throughout the therapeutic process, you may observe changes in your symptoms, concerns, and overall functioning. As we delve into more sensitive areas of your life, you may encounter increased difficulties during our sessions. While therapy generally leads to positive outcomes over time, it is possible to experience heightened emotions related to unresolved issues as we explore them further. I cannot make any promises or guarantees regarding the results you will achieve. However, by dedicating yourself to addressing your vulnerable areas and leveraging your strengths, it is probable that you will experience improvements both during our work together and in the future.

New Patients

There will be 1-2 initial visits to ensure proper assessment and thorough evaluation. Appointment(s) are 53 minutes. These appointments will be used to evaluate, educate and determine a mental health diagnosis. I may want to see you weekly until either your symptoms are alleviated, or your condition is stabilizing. We will work together to determine the best frequency of appointments going forward based on your health, treatment goals and stability of your condition.

Cancelling Appointments

In order to provide you with optimal care, your appointment time is reserved specifically for you. I do not double book clients. In return, I ask that you provide our front office with a minimum of 48 hours' notice if you are unable to make it to your appointment. Please call our front office staff for all scheduling needs at (425)-640-7009 to ensure prompt attention.

I work with all my clients on a reoccurring, weekly basis. If you cancel several appointments, I will ask that you be removed from your recurring appointment slot and be placed on my on-call list, as repeated cancellations present a barrier to the therapeutic process. If you are on the on-call list, I will reach out to you as appointments become available. If you have repeated no-show appointments, upcoming scheduled appointments may be cancelled.

Requests for Consultation

If you need a consultation outside of a scheduled appointment, please direct your request to me via the email or phone number listed. Mindful Therapy Group administrative staff are not clinically trained and are unable to respond to requests for consultation.

In general, my office hours are Monday, from 09:00 AM to 03:00 PM and Saturday, from 10:00 AM to 02:00 PM. I may not be able to respond to requests for consultation outside of these hours.

Emergencies

I am not available on an emergency basis. If you are experiencing an emergency or are concerned you may be a threat to yourself or others, please dial 911, 988 (an emergency line specific to suicide and mental health crises) or go to the nearest hospital emergency room.

Contact for Administrative/Scheduling Questions

If you have questions about scheduling, billing or technology, please contact Mindful Therapy Group at:

frontdesk.wa@mindfulsupportservices.com
scheduling.wa@mindfulsupportservices.com
425-640-7009
7:00am-7:30pm Monday-Friday
8:00am-4:00pm Saturday-Sunday

Rescheduling Appointments

Mindful Therapy Group and/or I will make every effort to provide you with adequate notice if I will be unavailable for a scheduled appointment.

If you need to reschedule an appointment, the rescheduling request should be made with Mindful Therapy Group, not me. If you need to reschedule an appointment, I ask that you give Mindful Therapy Group at least 48 hours' notice in advance of the originally scheduled appointment. Rescheduling requests made without 48 hours' advance notice will incur late cancellation fees (see Financial Responsibility section below).

Confidentiality

All information disclosed within appointments is confidential. I keep brief notes of our appointments, but such notes and other information related to these appointments will not be disclosed to anyone except as permitted or required by law.

Notice of Privacy Practices

The Mindful Therapy Group Organized Health Care Arrangement Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. An electronic copy of the Notice of Privacy Practices can be found here.

Your Rights

You have the following rights:

- To refuse treatment;
- To choose a practitioner and treatment modality which best suits your needs;
- To expect that I have met the qualifications of training and experience required by state law;
- To examine public records maintained by the state authority that licenses me and to have such authority confirm my credentials;
- To obtain a copy of the code of ethics to which I am bound;
- To report complaints to the Washington State Department of Health, which licenses me. Complaints can be made via email (mailto:hsqa.csc@doh.wa.gov), phone (360-236-4700), or web (https://doh.wa.gov/).

- To be informed of the cost of my services before receiving the services;

- To be assured of privacy and confidentiality while receiving services from me (note - the law sometimes permits or requires disclosures of private/confidential information); and

- To be free from free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Patient/Parent/Guardian Acknowledgment and Consent to Mental Health Treatment

I (the patient or the patient's parent legal guardian) have been provided a copy of my (or my child's) provider's disclosure statement. I have read and understand the information provided. I consent (or consent on my child's behalf) to receive mental health services from the provider named in this Disclosure Statement.

Patient Name:

Patient Date of Birth:

* If patient is under the age of 18 the patient's parent or legal guardian must sign below unless a minor patient is requesting to be assessed as a mature minor in accordance with state eligibility guidelines

Signed: _____

Name: _____

Relationship to Patient (e.g., self, parent):

_____

TELEHEALTH CONSENT

By signing below, you hereby consent to receive, or have your child receive, therapy services from me via telehealth. "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications.

There are benefits and risks to telehealth. The benefits of telehealth include convenience and continuity of care in times when you are unable to see me in-person. Risks include the risks inherent in transmitting information electronically that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. In the event of a technological failure during a telehealth visit, you agree that I may contact you at the phone number listed below.

It is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the telehealth technology. To further ensure the confidentiality and security of our communications, you are not permitted to record telehealth appointments.

All fees for telehealth services are the same as for non-telehealth services. You are financially responsible for all services rendered and for the charges associated with late cancellations and missed appointments, where such charges are permitted.

I may determine at some point during my treatment of you that treatment via telehealth is no longer appropriate. If this happens, we will discuss options for in-person care or referrals to other practitioners.

Patient Name:

Patient Date of Birth:

* If patient is under the age of 18 the patient's parent or legal guardian must sign below unless a minor patient is requesting to be assessed as a mature minor in accordance with state eligibility guidelines

Signed: _____

Name: _____

Relationship to Patient (e.g., self, parent):

_____

FINANCIAL RESPONSIBILITY

Insurance Fees

I am in-network with a select number of insurance companies for my services. Please provide full insurance information and your insurance card upon your initial visit (or before, if possible) so we can determine the benefits for which you are eligible. If you have a change in insurance, please let us know as soon as possible.

Your insurance plan may require me to assess you a copayment, coinsurance or deductible ("cost share"). Mental health appointments are assigned billing codes on claims that vary based on factors such as appointment length and complexity. As a result, your cost share may vary from visit to visit.

Any cost share is due at the time of service. Mindful Therapy Group staff and I will do our best to estimate your cost share in advance of or at the time of your appointment. However, it is possible that your insurance plan, after reviewing the claim, will determine that your cost share is higher than we estimated. In these situations, Mindful Therapy Group will notify you about any balance due with a monthly statement. In the event we overestimate the cost share, the credit will be applied towards your future visits, unless you specify otherwise.

If your insurance plan requires preauthorization for services, it is your responsibility to obtain this authorization prior to our appointment. If you fail to obtain authorization, any and all charges incurred for services rendered by me and not reimbursed to me or Mindful Therapy Group by your health insurance will be your financial responsibility.

Private Pay (Cash Pay) Fees

- $130 per 53-minute session for individuals.
- $150 per 53-minute session for couples/families.

Case Management Time Fees

Most clinical issues should be shared in our appointment. If calls and case management become excessive, I may need to charge for case management time. I will always inform you prior to providing this service and prior to billing for it.

- $100 per hour.

Cancellation Fees

If you are unable to provide more than 48 hours' notice, you will incur a missed appointment/late cancellation fee as follows:

- $115 for missing session

This charge is irrespective of the reason for the cancellation/no show. Insurance does NOT cover this fee and will automatically be charged to the credit card listed on file.

While I understand unexpected things sometimes pop up, if there is a pattern noticed of cancelled appointments, I may be unable to continue providing services to you, and I reserve the right to cancel future appointments in

order to make room for clients committed to the therapeutic process. I will always communicate about this with you and determine if we're a good fit prior to making changes to your scheduled appointments.

Collections

If you have an unpaid patient balance of $100 for more than 120 days, the balance may be turned over to a third-party collections agency. You will receive a final courtesy phone call and/or letter to remind you of your balance due. If you believe that there is an error in your billing, please let us know as soon as possible so we can research the issue. Unpaid balances without a payment plan or partial payment initiated after 120 days will initiate a phone collections effort for recovery, and some identifying confidential information will be released in this process. This may negatively impact your credit. It is very important that you update your contact information with us to ensure you are aware of your financial responsibility and receive your statements.

Assignment of Benefits

By signing below, in exchange for, and in connection with, any and all of the services provided to you or your child, as applicable, by me, your provider, you irrevocably assign and transfer to Mindful Therapy Group and me all of the rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that you or your child, as applicable, had, have or may have in the future pursuant to or in connection with any insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind covering you or your child, as applicable. This assignment also includes assignment of your or your child's, as applicable, appeal rights, fiduciary rights, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, and rights to notices and disclosures from any source that you or your child may have under the health benefit coverage described above.

Patient Name:

Patient Date of Birth:

* If patient is under the age of 18 the patient's parent or legal guardian must sign below unless a minor patient is requesting to be assessed as a mature minor in accordance with state eligibility guidelines

Signed: _____

Name: _____

Relationship to Patient (e.g., self, parent):

_____