Washington Therapist DISCLOSURE STATEMENT

April Hamilton, MA, CRC, LMHCA (Pending)
Sage River Counseling, PLLC
https://sagerivercounseling.com
april@sagerivercounseling.com
Phone: 206-482-1785

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 healthcare 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 am a Licensed Mental Health Care Associate, MC61149558, and am registered with the State of Washington, Department of Health as required by Law, and I currently meet all of the Washington State requirements for a Licensed Mental Health Care Associate. I am also a fully certified Vocational Counselor, 303140, as awarded by the Commission on Rehabilitation Counselor Certification. I hold a Master's degree in Clinical Mental Health Counseling from the University of Arkansas-Little Rock.

I have 15 years of experience in working with individuals aged 6-99 in a variety of settings. I have a decade of experience in helping people with chronic illnesses and injuries in identifying and obtaining meaningful employment and career goals. I also have experience in working with LGBTQIA2S+ individuals, anxiety, depression, parenting challenges, and currently training in sex education and therapy.

As a licensed clinician, I am required to participate in continuing education and am bound by the ethical framework determined by the Commission on Rehabilitation Counseling and the American Counseling Association.

I am formally supervised by Jesi Lingo, LMHC.

Additional information about my licensure is available at:

Washington State Department of Health: https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/mental-health-counselor/licensing-requirements

Commission on Rehabilitation Counselor Certification: https://crccertification.com/crc-certification/

American Counseling Association: https://www.counseling.org/

Patient Mix

I offer therapy services for individuals aged 15-99. I do offer case management services, which includes but is not limited to providing paperwork for disability, unemployment, custody, adoption, foster care, car accidents and any type of legal issues. I do offer therapy for individuals who are court-mandated for treatment or seeking treatment in which disclosure of appointments will need to be provided to an outside entity.

I offer career counseling which includes, but is not limited to resume development, ergonomic evaluations, job analysis reports, mock interviewing, and vocational evaluations.

Treatment Modality and Therapeutic Orientation

I provide individual therapy both in-person and online, using an integrative approach tailored to each client's unique needs. Just like a house isn't built with just one tool, neither is healing. I draw from a variety of evidence-based modalities-such as cognitive behavioral techniques, mindfulness, motivational interviewing, and somatic awareness-to support clients in understanding themselves, navigating challenges, and fostering lasting change. My work is rooted in collaboration, curiosity, and compassion, creating a space where clients feel safe to explore, grow, and heal.

Therapy has both benefits and risks. During the course of therapy, you might notice changes in your symptoms, problems, and functioning. Since we will be exploring challenging territory in your life, you might experience greater difficulty throughout our work. Therapy typically produces benefits over time, but sometimes as you get to the root of tender issues, you may feel them even more acutely than in the past. I cannot offer any promise or guarantee about the results you will experience. However, as you commit yourself to work through your vulnerable issues and build upon your strengths, it is likely that you will see improvements throughout our work 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 recurring, 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 and you may be placed on same-day scheduling.

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 2:00 pm to 8:00 pm from Tuesday-Thursday. I will 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 state authority that licenses me:

Department of Health Health Systems Quality Assurance Complaint Intake 360-236-4700 HSQAComplaintIntake@doh.wa.gov P.O. Box 47857 Olympia, WA 98504-7857	Ethics Committee CRCC 1699 E. Woodfield Road Suite 300 Shaumburg, IL 60173

- 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

As a provider, I understand the unique challenges that arise when working with minors. While I am committed to providing the best care possible, it is important to acknowledge that parental involvement is a critical component of the treatment process. I have created a section in my intake paperwork disclosure that outlines the expectations around parental involvement. This section will include information regarding the importance of following treatment recommendations and the treatment plan, as well as any consequences that may arise if these recommendations are not followed.

It is important to note that while I make every effort to work collaboratively with parents, there may be situations where my professional judgment may differ from the wishes or expectations of parents. In these instances, I will prioritize the wellbeing and best interests of the minor. Please read through this section

carefully and let me know if you have any questions or concerns. Thank you for entrusting me with the care of your child.

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.

Medicaid clients cannot be assessed no show or late cancellation charges. If you are working with Medicaid your provider disclosure must include the following language:

In accordance with WAC 182-502-0160, if you are using Washington Apple Health (Medicaid) to cover services, I may not bill you for the following:

- Services covered under your Apple Health plan, even if I have not yet been paid.
- Services denied because of provider error (such as missing prior authorization or required documentation).

- Missed, canceled, or late appointments.

You may only be billed for services that Apple Health does not cover if you sign an “Agreement to Pay for Healthcare Services” before receiving those services. If Mindful Therapy Group is not contracted with your Apple Health plan, you may be responsible for fees and any cost-sharing as determined by your plan.

For more details, please refer to your Apple Health plan documents or applicable Washington regulations.

Private Pay (Cash Pay) Fees

- $100 per 55-minute session for individuals
- $120 per 55-minute session for career counseling

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.

- $125 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:

- $100 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):