DISCLOSURE STATEMENT

Elizabeth R. Jones, M.Ed., LMHCA, NCC
GINGER'S GRACE THERAPY COMPANY PLLC
100 N HOWARD ST, STE R SPOKANE, WA 99201-0508
eljoneswa@ggtcpllc.com
(601)-715-6148

I have partnered with Mindful Therapy Group for administrative services. If you have questions regarding billing or technology issues, please contact: frontdesk@mindfultherapygroup.com
425-640-7009
7 am-7 pm Monday-Friday
8 am-4 pm Saturday-Sunday

If you have any questions about insurance, please call Mindful Therapy Group before your scheduled appointment to avoid paying out of pocket.*

WAC 246-809-710 requires counselors to disclose the following information in writing to their clients.

Before signing this document, please read this disclosure statement in its entirety. This information is to help you decide whether my services are suitable for your needs. Please discuss any questions or concerns before treatment or as they arise during your course of treatment.

Independent Practice: I am an independent contractor 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.

Credentials and Education: I am an independent Licensed Mental Health Counselor Associate (LMHCA) in Washington State, with license #MC61680865. With five years of Expertise in Education and Mental Health, I have a master's in Education, specializing in School Counseling, and have met all requirements to become a Nationally Certified Counselor (NCC). To further enhance my professional development, I am a member of the American Mental Health Counseling Association (AMHCA), the Washington Mental Health Counselor Association (WMHCA), and Chi Sigma Iota. I adhere to the rules, regulations, and code of ethics set forth by the Washington State Department of Health and the American Counseling Association. As a licensed clinician, I am required to participate in continuing education. Currently, I am under the supervision of Emmaleen Edwards, LMHC, whose Washington state license number is LH60301201. Additional information about my licensure is available at: https://fortress.wa.gov/doh/providercredentialsearch/

Philosophy and Treatment Modality: As an LMHCA, I utilize a humanistic, integrative approach to therapy, believing that everyone has the internal strength and capacity to develop, heal, and effect major change. Through a collaborative, authentic therapeutic relationship, I strive to provide a culturally sensitive, supportive, and nonjudgmental atmosphere in which you can safely explore your experiences. The three main approaches to therapy that serve as a foundation are:

- **Person-Centered Therapy,** which encourages empathy, sincerity, and unconditional positive regard to help you self-explore and grow.
- **Adlerian therapy** looks at early experiences, social context, and building a stronger feeling of purpose and belonging.
- **Solution-focused therapy** emphasizes your strengths and assists you in developing realistic, goal-oriented actions toward change.

I also use complementary techniques from **Cognitive Behavioral Therapy (CBT), Narrative Therapy, Gestalt Therapy, Existential Therapy, Mindfulness-Based Practices, Acceptance and Commitment Therapy (ACT), and Trauma-Informed Care.** These techniques are designed to address a variety of concerns, including anxiety, depression, trauma, grief and loss, identity formation, life transitions, self-esteem, and stress. Together, we'll explore what healing looks like for you and map out an individualized action plan.

Benefits and Risks. Therapy has both benefits and risks. You might notice changes in your symptoms, issues, and functioning throughout our sessions. As we explore challenging areas in your life, you might experience difficulty throughout our work. Therapy typically helps ease or heal one's issue over time, but occasionally, as you get to the root of tender issues, you may feel them even more during or after sessions than you did in the past. I cannot offer any promises or guarantee an outcome from this experience. However, as you commit to working through your vulnerabilities and building on your strengths, you will likely see improvements throughout our work and in the future.

Artificial Intelligence: Artificial Intelligence (AI) tools may be integrated into your sessions to complement the therapeutic process. Your privacy and confidentiality while utilizing AI tools are of utmost importance. Any data entered into AI tools will be securely stored in accordance with HIPAA privacy guidelines. I have read and understood the above information and consent to the utilization of AI to support the therapeutic process. I understand that my consent is voluntary and that I have the right to withdraw it at any time.

Clientt Name:_____
Client Date of Birth:_____

(*If the patient is unable to consent)
Signing on behalf of:_____
Relationship to Client:_____
Print name: _____
Signature Responsible Party: _____

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Session Length & Frequency: Individual sessions are usually **53 minutes** long or less, typically at a frequency determined by your specific therapy needs. If you need more or fewer sessions, we will discuss this together and work out an arrangement that suits your needs.

The allotted 1-hour (60-minute) time slot includes session time, documentation, and insurance claim submission. The therapist will end the session before the 60-minute mark to complete all necessary documentation and claims for the client's allotted time

Client's Rights and Responsibilities: Clients have the right to choose a therapist who best suits their needs and purposes. You may ask questions about treatment at any time and may choose to terminate therapy at any time. Therapy may also end when I feel another provider will better meet your needs. In that case, I will make appropriate referrals. If you have any concerns or complaints, you may contact:

Department of Health
Health Systems Quality Assurance Complaint Intake
360-236-4700
HSQAComplaintIntake@doh.wa.gov
P.O. Box 47857
Olympia, WA 98504-7857

Clients also have the right to be informed of the cost of my service before receiving the service; to be assured of privacy and confidentiality while receiving services from me, and to be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Services: I offer therapy services for individuals and couples. Group therapy services will be offered at a later time. I see clients aged **18-65.** I **DO NOT** offer case management services, which include but are not limited to providing paperwork for disability, unemployment, custody, adoption, foster care, car accidents, and any type of legal issues. I **DO NOT** 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.

Virtual Sessions: I _____ (client's name) hereby consent to engage in Telehealth. I understand that "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using an encrypted system that meets federal standards and is HIPAA-compliant. It is my 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 overhear our communications or gain access to the technology we are using. Additionally, I agree **NOT** to record any Telehealth sessions. During a Telehealth session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. I will ensure I have my phone with me and have provided my phone number above**. I am financially responsible for all services rendered, late cancellations, and missed appointments not covered by insurance**.

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Assessment and Diagnostic Review: To support quality care and track treatment progress, clients may be asked to complete brief symptom assessments through **Greenspace** approximately once per quarter. **Greenspace** is a secure client assessment platform that collects and monitors information on symptoms, functioning, treatment goals, and overall progress. A quarter refers to a three-month period of the year: January–March, April–June, July–September, and October–December. When an assessment is due, clients will receive an email notification with instructions and a link to complete it. These assessments may include questions related to mood, anxiety, functioning, treatment goals, or DSM-5 diagnostic criteria when clinically appropriate. The purpose of these reviews is to monitor progress over time, provide clients with meaningful data on their growth, identify areas that may need additional support, and guide ongoing treatment planning in a thoughtful, collaborative way.

Emergencies: As an independent, private practicing clinician, **I DO NOT** offer crisis services. If you are experiencing an emergency or a threat to yourself or others, please call 988 or go to the nearest hospital emergency room. You may call 1.866.4CRISIS (1.866.427.4747) for urgent mental health crises.

Social Media and Electronic Communication Policy: I **DO NOT** offer therapy via email or text for any reason. If you are experiencing a crisis, please refer to this disclosure statement's (emergencies) section. I only accept calls for appointment cancellations or if our session connection is disrupted. You will be able to access your appointment time through your client portal. If you attempt to contact me on social media, I will decline or reject your request. Please understand that social media engagement is prohibited for my privacy and personal safety. I will not engage in your social media accounts as the client. If I see you in a public setting, I will not contact you for your privacy and confidentiality purposes.

Financial Responsibilities: Please confirm your insurance coverage and patient responsibility before your first appointment with me. Your co-pay or patient responsibility (deductible), determined by your insurer, is due at each visit before your session begins. My private pay rate is **$120** per 50-minute session for **individuals** and **$125** per 50-minute session for **couples**.

Consider that you cannot pay the associated fees for more than one visit at the time of service without creating a payment plan. In that situation, your future appointments will be postponed until delinquent balances are settled. Additional fees may apply when preparing requested papers or copying and mailing records. I will discuss any fees with you at the time of the request. If you would like to receive a statement for your coinsurance rather than paying at the time of service, MTG will provide one upon request.

Your appointment time is reserved specifically for you, and I ask all my clients to respect this time. A **minimum** of a **24-hour** notice is required to reschedule or cancel **without** a fee. A fee is charged for cancellations made with less than **24 hours' notice** and **for no-shows**, at my discretion. Insurance **cannot** be billed for late rescheduled, canceled, or no-show sessions. Since this fee is assessed at my discretion, please direct all questions to me rather than the administrative staff. An amount of **$125** will be charged to the client automatically by Mindful Therapy Group once the therapist has marked the session as appropriate.

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Sessions will be marked **canceled 10 minutes** after the session start time without the client present unless discussed with the therapist before the session start time.

Quarterly Grace Cancellation Policy: Clients are allowed **one courtesy late-cancellation or missed-session-fee waiver per calendar quarter**. Quarters run January–March, April–June, July–September, and October–December. This courtesy waiver **resets at the beginning of each new quarter and does not roll over**. Any additional late cancellations, missed appointments, or no-shows within the same quarter **WILL BE** subject to the standard cancellation fee on file.

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

- Services covered under your Apple Health plan, even if I have not yet been paid for them.
- Services are 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 the applicable Washington regulations.

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.

I authorize my provider, **Elizabeth R. Jones,** at GINGER'S GRACE THERAPY COMPANY, PLLC, and Mindful Therapy Group to release information to the listed insurance carrier(s) and be paid directly by the insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, missed and late reschedules, or cancellation fees. If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature of Financially Responsible Party: _____
Relationship to patient: _____
Date: _____

Confidentiality and Access to Records: All information disclosed within sessions is confidential. It will not be disclosed to anyone without your written permission. Disclosure will be required when a client is a danger to themselves or others. I keep brief notes of your sessions in a HIPAA-compliant portal. You have the right to a copy of your medical records at any time. A response to your request will be provided within 15 working days, in compliance with RCW 70.02.080.

My signature below is an acknowledgment that I am the client or the person authorized to consent to mental health treatment for the client, and that I consent to services provided by **Elizabeth R. Jones**, Licensure #MC61680865. I have read and understood the disclosure information and have received a copy of this disclosure form.

Clientt Name:_____
Client Date of Birth:_____

(*If the patient is unable to consent)

Signing on behalf of:_____
Relationship to Client:_____
Print name: _____
Signature Responsible Party: _____

Assignment of Benefits: In exchange for, and in connection with, any and all of the services provided to you or your child, as applicable, by your Provider, you irrevocably assign and transfer to Mindful Therapy Group and your Provider 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 health insurance policy or plan, health benefit plan, health management agreement, healthcare risk-bearing agreement, healthcare trust, healthcare fund or any other source of payment, healthcare insurance, healthcare indemnity or health or medical coverage of any kind covering you or your child, as applicable to healthcare. 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.

Clientt Name:_____
Client Date of Birth:_____

(*If the patient is unable to consent)

Signing on behalf of:_____
Relationship to Client:_____
Print name: _____
Signature Responsible Party: _____