Kristi Dechairo Ahern MAEd in Counseling, LMHC, NCC
Disclosure Statement
Licensed Mental Health Counselor #LH60964213

Welcome! I am a state licensed mental health counselor and a nationally certified counselor. I provide Telehealth therapy for individuals living in Washington State. My work with clients focuses on helping identify and alleviate problems interfering with personal goals and relationships. I believe in a collaborative, client-centered approach. The following guidelines describe your rights and our mutual responsibilities during our counseling relationship:

Client Rights

As a client, you have the right to refuse treatment or to ask me to refer you to a different therapist. If you have any concerns about the counseling I provide, please let me know. You may also contact the Washington State Department of Health, Professional Quality Assurance Division, PO BOX 47869, Olympia, WA 98504 or call 360-236-4902.

Approach to Treatment

I work with adults. My primary treatment method is eclectic, which means that I use a variety of methods and techniques, depending upon the client's needs. I will conduct an initial assessment and then together, we will discuss an appropriate treatment plan and goals. I have experience in counseling individuals dealing with anxiety, depression, self-esteem, stress, trauma, grief, family conflict, and adjustment, identity, and relationship issues. I believe that establishing a trusting, therapeutic relationship makes it possible to heal from issues creating distress and interfering with one's personal goals and ability to create lasting and healthy relationships.

Education and Experience

I have a Bachelor's degree in Sociology from the University of California, Santa Cruz and a Masters of Education Degree in Counseling from Seattle University. I have experience providing individual and group therapy to adults, children, teens, and families.

My NPI number is 1316463631, My Tax ID number is 47-4373520

Fee Information and Payment Policy

The fee for each 55 minute counseling session is $150. Payment is due at each session. There is no charge for phone calls of 5 minutes or less. I am happy to bill most insurance companies however, it is your responsibility to determine if your insurance company will pay for counseling and if it is not covered, payment will be your responsibility. Please be sure to pay your co-pay, deductible or full payment at the beginning of each session. If I am not in-network with your insurance company, you will be responsible for any difference between what I charge and what your insurance company pays for the service. If you choose to pay by credit card, there will be an additional $1 service fee per session.

The signature at the end of this form will be considered your signature on file for the purpose of billing your insurance company and payment will be submitted directly to me. Any letters written on your behalf will be billed at my normal hourly rate. I cannot bill insurance for these letters. Your appointment time is held especially for you. If you are unable to keep your appointment, please call me to cancel or change your appointment at least 24 hours in advance otherwise you will be charged $100 unless there is an emergency. I am unable to bill your insurance company for missed appointments so this fee will be your responsibility. The session will begin and end at the scheduled time regardless of when you arrive.

I will not be able to provide a diagnosis or a proposed course of treatment until I have spent some time with you. Additional services may be recommended. Sessions will be provided bi-weekly or weekly until treatment is terminated.

Good Faith Estimate

A Good Faith Estimate will be provided to you electronically at the start of services. If you are using insurance, this estimate will provide confirmation of your benefits and state what your copay and/or deductible will be for these services. Please note that this estimate is subject to change as details of your benefits change and/or your deductible is paid down. If you are paying out of pocket (i.e., not using insurance) for services, the Good Faith Estimate will outline the expected cost of services for the remainder of the year. This estimate will be based on an initial assessment of your therapeutic needs. As we work together, additional services may be recommended. This estimate of your costs is only an estimate, and your actual charges may differ. You have the right to initiate the patient–provider dispute resolution process if the charges you are billed substantially exceed the expected charges in this estimate. This estimate of costs is not a contract and does not obligate you to obtain clinical services from New Vision Counseling.

Confidentiality

All issues discussed in therapy are confidential. However, the law requires the release of confidential information for the following reasons: if you disclose that you wish to harm yourself or someone else, suspected child abuse, elder abuse or a court subpoena.

Substance Abuse

It is important to think clearly within a therapy session. Please do not drink alcohol or take any non-prescription medication before a session. If you appear to be impaired during the session, we will need to terminate the session and reschedule, however, you will still be responsible for payment of the session.

State Laws

WAC 30-109900 "Counselors practicing for a fee must be registered or certified with the Department of Licensing for the protection of public health and safety. Recognition of an individual with the Department does not include any recognition of practice standards, or necessarily imply any effectiveness of any treatment." SHB 1828 "A record of the mental health care provided to you is kept by this office. You may ask to see a copy of this record. You may also ask the office to correct the record if you believe the information is in error. A copy of the correction to the record will be placed within your record, at your request. This office will not disclose your record to others unless you request me to do so in writing or if

the law authorizes or compels me to do so. You may see your record, or get more information about it, at this office."

Telehealth

I understand that telehealth allows my therapist to diagnose, consult, treat, transfer of health information/records, and educate using interactive audio, video, or data communication regarding my treatment.

I understand I have the right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Therefore, the same exceptions to confidentiality (as stated in confidentiality section) apply.

I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would be otherwise entitled.

I further understand that there are risks unique and specific to telehealth, including, but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In the event of a technical problem, my provider will contact me by telephone to complete the session and arrange for another time or new connection to try again. In addition, I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

Telehealth by Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Telephone contact numbers

My office number is 425-292-1192. My email address is kristi@newvisioncounseling.net. If I am not available, I will do my best to return your call as soon as possible. If your call is due to a life threatening emergency, please call 911 or go to the nearest emergency room. I am not available after hours. If you need to talk with someone right away, please call the Crisis Clinic at 206-461-3222.

Client Acknowledgement I have read and understand this disclosure information and have been given the opportunity to ask questions and clarify its content. I have also been given a copy and signed the Notice of Privacy Practices and the Good Faith Estimate Disclosures Form.

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Client Name	Date	Signature
_____	_____	_____
Therapist Name	Date	Signature