DLK Counseling
2366 Eastlake Ave E, Suite 232
Seattle, WA 98102
Phone: 206 851 7450

DISCLOSURE STATEMENT
David Lee Kahle, LMHC
DLKCounseling.com

Please take the time to carefully read this disclosure statement. It describes my private practice policies, my qualifications, and your rights as a client.

Licensure and Approach to Therapy:
I have a Master of Arts in Counseling Psychology from Argosy University. I am a licensed mental health counselor in Washington State, LH 60753550. I have also achieved additional standards for education, training and experience leading to certification by the National Board of Certified Counselors, Cert 326476. I have been practicing mental health therapy since 2012. At any time, you have a right to file a complaint with the State of Washington, by contacting: Department of Health, Town Center 2, 111 Israel Road SE, Tumwater, WA 98501 (360-236-4700)

I have experience working with youth and family services, outpatient psychiatric clinic and in private practice. I have a special interest in treating depression, anxiety, trauma, men's issues and many others. I use an empathetic approach that focuses on each client's unique values and goals for therapy. Therapy is best when collaborative. I encourage feedback and direction on our goal creation and execution. Therapy includes risks, such as uncomfortable feelings, but typically leads to great benefits.

Confidentiality and Access to Records:
All information from our sessions is confidential and may not be shared to anyone without your written permission except where law requires disclosure. Disclosure may be required where there is a reasonable suspicion that the client presents a danger of violence to others or to himself. Court orders may also require disclosure. I keep brief notes of your sessions. You have the right to a copy of these records at any time. A response to your request will be made within 15 working days; this is in compliance with RCW 70.02.080.

Telehealth
You signature below, is consent to engage in Telehealth as well as in-person therapy. 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 a system that is encrypted to the federal standard and HIPAA compatible. 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 either overhear our communications for have access to the technology that you are interacting with. Additionally, both parties agree not to record any Telehealth sessions. During a Telehealth session, we could encounter a technological failure. The most reliable back up plan is to contact one another via telephone. I will ensure that I have my phone with me. The phone number is 206-851-7450.

Costs and Billing Practices:
Therapy appointments are scheduled from 45-53 minutes each. The standard fee for a treatment session is $110. All fees are due at time of service. Payment in full is due at the time of each session including private pay amounts, copays, coinsurance and deductibles. You will be billed for any remaining balance. If an unpaid balance remains after 60 days, your balance will be turned over to a collections partner, and you will receive a series of

phone calls and letters to remind you of your balance due. If you believe there is an error in billing, please let me know as soon as possible and I will research the issue.

Cancellations

I ask you provide a minimum of 48 hour's notice if you are unable to make it to your appointment. Please leave me a voicemail, 206-851-7450 if you plan to cancel a session. If you are unable to provide me with this notice, you will incur a missed appointment/late cancellation fee of $90. This charge is irrespective of the reason for the cancellation/no show. Insurance does NOT cover this fee.

Client Consent to Treatment

Client Name: ______________________________

*The following section is in reference to receipt and agreement with the **Disclosure Statement**.*

My signature below is acknowledgement that I am the client, or the person authorized to consent for mental health care for the client, and consent to services provided by David Lee Kahle, LMHC, that I have read and understand the disclosure statement provided by David Lee Kahle, LMHC, and that I have received a copy of this disclosure form.

_____________________ _____________ ________________________
Client's Name (Printed) Date Person Authorized to Consent

____
Client's Signature

_____________________ ______________
David Lee Kahle, LMHC Date