



CONSENT FOR TREATMENT

I hereby authorize **Aneta Kucharczyk-Swamy, ARNP** to provide treatment and/or psychotherapy as explained to me. I understand that while this therapy may be beneficial, as with any treatment, there are inherent risks. During treatment, I will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. I acknowledge, however, that no warranty or guarantee can be made as to the results of therapy or medication management.

CONFIDENTIALITY: I understand that discussions between myself and my provider/therapist as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the provider/therapist has a duty to disclose, or where, in the provider's/therapist's judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the provider/therapist, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my provider/ therapist. By signing this Information and Consent Form, I am giving consent to the undersigned provider/therapist to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless the undersigned provider/ therapist from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my provider/therapist believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my provider/therapist is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Treatment and/or psychotherapy as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, treatment (including medication management) and other services for me or my child (if client is a minor), and I understand that I may stop such treatment or services at any time.

SERVICES

Mindful Minds, LLC is a solo private practice located in Seattle, offering psychiatric care and medication management for children, adolescents, and adults. I provide comprehensive evaluations and treatment for a variety of mental health conditions, with both in-person and telehealth (video) services available. In-person visits are available on Fridays.

My psychiatric and mental health services include:

- Comprehensive psychiatric evaluations and medication assessments
- Ongoing medication management and treatment
- Psychiatric medication and treatment consults (second opinions)
- Psychoeducation and mind-body health coaching
- Supportive psychotherapy utilizing mindfulness meditation, and elements of the following therapies: CBT (Cognitive Behavioral Therapy), DBT (Dialectical Behavior Therapy), ACT (Acceptance and Commitment Therapy), and trauma-informed counseling.

Consent for Use of Online Third-Party Screening Tools

By signing this consent, I also understand that my provider may use secure, third-party platforms such as www.mhs.com, www.wpspublish.com, www.NovoPsych.com, and Q Global/Pearson web based administration, scoring, and reporting systems to administer psychological or behavioral screenings/tests. These platforms allow assessments to be completed online and submitted electronically for scoring and interpretation.

I consent to receiving questionnaires via email and completing them through these secure portals. I understand that my responses may be linked to personal identifiers such as my **name, date of birth, age, and gender** in order to ensure accuracy and generate tailored reports. These identifiers will only be used as necessary for the purpose of completing the assessments and interpreting results.

I acknowledge that these platforms comply with privacy and security standards, and that my provider will take appropriate steps to protect the confidentiality of my information. I understand that I may withdraw my consent at any time, and I can contact my provider with any questions or concerns.

By signing below (or submitting the form), I agree to the use of these online tools as part of my care.

<http://platform.wpspublish.com...>

<https://mhs.go-vip.net/wp-cont...>

<http://mhs.com/privacy-policy/>

<https://mhs.com/compliance/>

<https://mhs.com/digital-trust/>

[Pearson /Q-Global Legal Agreements](#)

[NovoPsych Privacy Policies](#)

AFTER-HOURS AND CRISIS. WARNING

Individuals with high-acuity needs or unstable conditions may require a higher level of care. If that applies to you, I can provide referrals to more appropriate services.

As a solo provider working part-time, I do **not** offer on-call coverage and am unavailable for phone calls or consultations outside of office hours. I check messages during the workweek and will do my best to respond within **three business days**. If you require more frequent access to a psychiatric provider or a

treatment setting with additional resources, I'm happy to offer alternative options and referrals.

For urgent clinical crises outside of business hours or on weekends:

- **Emergencies:** Dial 9-1-1
- **King County Crisis Clinic:** 1-866-4-CRISIS (1-866-427-4747) or (206) 461-3222
- **Southwest Washington** 1-800-626-8137
- **Pierce County** 1-800-576-7764
- **North Central Washington** 1-800-852-2923
- **Care Crisis Response Service:** 1-800-584-3578 or call or text 988

www.crisisconnections.org/24-hour-crisis-line/

<https://988lifeline.org/>

Seattle Children's Mental Health Urgent Care

<https://www.seattlechildrens.org/clinics/psychiatry-and-behavioral-medicine/psychiatric-urgent-care/>

Teen Link (Open 7 Days a Week 6-10pm)

Call & Text 866-833-6546

<https://www.teenlink.org/>

I observe major holidays and take vacation a few times a year. I will provide at least 2 **weeks' notice** so we can plan accordingly or discuss short-term coverage options.

CONTACT.

Mindful Minds, LLC is a part-time solo private practice, which means there are limitations on the scope of clinical services provided in an outpatient setting.

I encourage you to register with the **patient portal**, where you can securely send messages, review and upload documents or lab results, pay outstanding balances, and manage your appointments—including rescheduling or canceling up to **24 hours before** your visit.

For routine or non-clinical matters, please email me at **anetaks@mindfulmindsllc.com**. You can also reach me on my main office line at **(206) 207-0463**, which goes to a secure voicemail. While voicemail messages are forwarded daily, they are **not monitored outside of business hours**.

Important: Please **do not** leave urgent, time-sensitive, or critical clinical or therapeutic concerns via email, text, or voicemail. These digital communication methods are not fully secure, and using them may put your confidentiality at risk.

OFFICE APPOINTMENTS.

Your initial visits will focus on establishing care, identifying a mental health diagnosis as a treatment framework, and collaborating on a personalized treatment and wellness plan. These early appointments help us build a therapeutic partnership and determine if we are a good fit for ongoing treatment. Please note that I do **not** automatically prescribe, refill, or adjust medications during your first visit.

Appointment Types:

- **INTAKE Appointment** (Up to 90 minutes) This comprehensive evaluation includes a review of your history, current concerns, and strengths. We will discuss both short-term and long-term treatment goals. If medications are part of your treatment plan, we will review their potential benefits, risks, side effects, and effectiveness. Requests for past records, pertinent lab work, or referrals for counseling/therapy are

common recommendations following this visit.

- **STANDARD FOLLOW-UP Appointment** (30/45/60 minutes) A brief check-in to review symptoms, assessments, treatment progress, and goals. Medication refills and referrals can be addressed during this visit. Brief counseling may also be included as needed.

- **EXTENDED FOLLOW-UP Appointment** (60 minutes, mostly for ADHD/Autism evaluation) A more in-depth session for reviewing symptoms, adjusting medications, and discussing treatment progress. This appointment allows for additional time to explore significant medication changes and provide specific counseling. Some patients choose this option for a combination of medication management and longer counseling or treatment planning.

FEES.

Like many appointments with other medical specialists, office visits with a psychiatric nurse practitioner are billed based on many factors including factors such as time, complexity, medical issues, acuity, amount of psychiatric intervention or planning, counseling, patient education, etc. As a result, your copay/coinsurance and the length of the appointment can be different for each visit. There is no charge for routine telephone calls for basic administrative tasks such as scheduling appointments or for billing questions. However, I reserve the right to bill my standard hourly rate (\$200) for extraordinary circumstances, such as coordinating hospitalization, clinical and legal forms, and extensive phone consultations outside of appointments, exceeding 15 minutes per week. Since you cost-share with your insurance company, I will do my best to estimate your portion, at the time that you check in for your appointment. Despite our best efforts, it is possible that once I get the insurance claim back (usually 2-6 weeks after it is submitted), your cost-share may be higher than originally anticipated. I will notify you about any unpaid balances via patient portal and email. You can settle any balances during your appointment in the office. Prompt payment is always appreciated.

I am currently in network with **Premiera Blue Cross, Regence Blue Shield, Cigna/Evernorth, Aetna, Coordinated Care/Ambetter and Molina (Medicaid and commercial plan).**

I am also in network with **Ambetter, Carelon Behavioral Health, Quest Behavioral Health, Blue Cross Blue Shield of Massachusetts, Oscar (Optum), United Healthcare (Optum) and Oxford (Optum) through Headway** mental health and billing platform (I only use Headway platform for clients with these insurance companies and headway will send clients additional agreements necessary for billing). If you want to use any of these insurance plans you need to sign up through Headway and here is my profile: [Headway](#).

Please contact your insurance to verify if I am in the network with your plan as the information above may not be up to date.

Initial evaluation for new clients is billed as CPT code 99205 for 60-74 minutes, follow up 40-54 minutes visit is billed as 99215 and 30-39 minutes visit is billed as 99214. There are add on codes for prolonged and additional services: 99417, 96112, 96113, 90885, G2212, 90846, 96160 and 99367. My NPI # is 1760818553.

I accept **private pay /self-pay** clients. Fees are due at the time of service. These fees may be adjusted/reduced depending on each individual's circumstances.

Initial psychiatric evaluation including for Autism/ADHD evaluation (60-90 minutes): \$300-\$350

Follow up Autism/ADHD evaluation visit (60 minutes): \$300

Feedback and recommendations planning visit for Autism/ADHD (60 minutes): \$250

Follow up visit (60 minutes): \$250

Follow up visit (45 minutes): \$200

Follow up visit (30 minutes): \$150

*Fees subject to change. Check my website for the most updated fees/rates for services. Autism and ADHD evaluation may require few visits to complete, depending on complexity. Expect 3 visits on average and 1 follow up/feedback visit. ADOS-2 testing will require additional visit.

OTHER FEES.

*Services provided outside of the usual appointment time, including telephone conversations lasting longer than 15 minutes per week, preparation of documents, care co-ordination, or extensive interactions with insurance companies will be billed at a pro-rate of \$200 per hour.

*Late Cancellation/No Show Fee is \$150. If you fail to show up for your appointment or do not notify me in advance, please note that you will be charged this standard fee for the missed session. To avoid the fee, cancellations or rescheduling must be made with at least 24 hours' notice, allowing me to offer the time slot to someone on my waiting list. This fee is not covered by insurance and it applies to every patient.

PAYMENTS.

Payment is due at the time of service - this includes any co-pays, co-insurance balances, or other unpaid balances. I accept credit cards/HSA cards via patient portal: Practice Q or via Square Payments. Before your first appointment, please check with your insurance whether I am an in-network provider, under YOUR specific plan. It is important that you know what costs to expect regarding co-pays, co-insurance, and/or meeting any deductibles. If your insurance plan offers "out-of-network" coverage, you will need to pay for services directly but I can provide you documentation of payment for services, so you can submit a claim to be directly reimbursed by them.

I also use Headway to manage my billing and admin work so that I can place all of my focus on our work together. Headway manages everything related to payments and insurance to make things as easy as possible for you. The Headway team will reach out with an email to help you set up your account and add your insurance and payment details. You'll see your cost per session ahead of time and can check your benefits through the client portal. Clients who booked via Headway will have most billing handled only by Headway. I also sometimes use Headway for billing for clients that book directly with me. Working with Headway will require few additional consents.

SERVICE DISCLAIMERS.

If you are taking a controlled substance such as a benzodiazepine (e.g., Klonopin, Ativan, Xanax, Ambien) or stimulant (e.g., Adderall, Ritalin), please note that **refills are not guaranteed**. Research has shown that long-term use of benzodiazepines and hypnotics can harm your health, are highly addictive, and increase the risk of permanent memory damage. We can discuss options, including a safe taper and alternative treatments.

I **do not** assist with short-term or long-term disability forms, especially for new patients, as these require an established therapeutic relationship with an ongoing provider. Additionally, I **cannot** refill medications prescribed by other doctors for non-psychiatric conditions, such as muscle relaxants or opioid pain medications, as this is outside my scope of practice.

MORE ABOUT DISABILITY PAPERWORK.

As part of my practice, I am able to complete disability paperwork only for established patients. This

means I cannot complete any disability-related forms during the first visit or early stages of treatment. Before I can consider completing such paperwork, I require:

- Previous psychiatric records
- A signed Release of Information (ROI) form for your current Primary Care Provider (PCP), therapist, and any previous mental health providers.

This information is necessary to ensure I have a full understanding of your treatment history and to allow me to collaborate effectively with your treatment team.

My goal is to support your mental health recovery and help you return to optimal functioning in daily life, including your work and/or school responsibilities.

REFILLS.

Medication refills should be requested during your appointments to ensure we can discuss their effectiveness, potential side effects, and any concerns. As your provider, it is my responsibility to monitor your treatment progress and medication effects.

Please track your supply to avoid running out before your next visit. If you cancel an appointment and run low on medication without rescheduling in a timely manner, a **\$50 refill fee per medication** may apply. If I have not seen you in over **three months**, a follow-up appointment will be required before a refill can be issued.

Refill requests may take **2-3 business days** to process. If I am in the office, I typically handle them by the end of the day, but I am only in the office **two days per week**. If you haven't received a response within this timeframe, feel free to follow up.

COLLECTIONS EFFORTS.

Unpaid balances past **60 days** will receive reminders via phone, email, and mail before being sent to collections. If I don't hear from you, a certified letter will notify you of possible termination from the practice due to nonpayment.

Billing issues can happen—just keep me informed, and I'll work with you. Payments can be made easily online through the **patient portal**. If you believe there is a billing error, please contact me as soon as possible so we can resolve it together.

DISMISSAL/TERMINATION OF CARE.

You may end your treatment with me at any time. With a signed **Release of Information (ROI)**, I can transfer your records to your new provider. Once terminated, I can no longer provide care or refills.

I may also terminate care for reasons including:

1. Disrespectful or belligerent behavior toward me or staff.
2. **Three** missed appointments (no-shows/late cancellations).
3. Non-payment of balances **over 60-90 days**.
4. Misusing, overusing, or selling prescribed medications.
5. "Doctor shopping" (seeking prescriptions from multiple providers without disclosure).
6. Non-compliance with the treatment plan.

If a higher level of care (e.g., inpatient, intensive outpatient, rehab, or community mental health services) is clinically necessary, or if another specialist is better suited for your needs, I will communicate my recommendations as part of your treatment plan.

PRIVACY & CONFIDENTIALITY.

Your treatment information is **confidential** and will only be shared with your **written or verbal consent**, except in specific legal situations. You can review the **HIPAA Privacy Form** in your **intake packet** for details. I maintain strict privacy standards and will discuss any disclosures with you to ensure you're informed.

Exceptions to Confidentiality (Mandated Reporting):

I am legally required to report:

- Suspected **abuse or neglect** of a child, dependent adult, or developmentally disabled person.
- **Suicidal/self-harm behaviors** requiring immediate medical attention.
- **Threats of harm to others**—I must inform law enforcement and the potential victim.
- **Urgent care coordination** with other providers (e.g., ER, PCP, therapist).
- **Case consultations** with a supervisor/psychiatrist/ARNP.
- **Court orders** or subpoenas for treatment records.

My practice and medical software comply with **HIPAA policy**. The **Notice of Privacy Practices** included in this initial packet explains your rights in detail.

I appreciate your time and look forward to working with you!

If you are signing this form as a parent or guardian, please state your child's name here:

_____ Client Signature	_____ Date
_____ Therapist Signature	_____ Date
_____ Witness Signature	_____ Date