Awen Therapy
Counseling for individuals, partners, and families
2564 Branch St, Ste B5, Middleton, WI 53562
(608) 492-0069 AwenTherapy.com

INSTRUCTIONS FOR COMPLETING INTAKE FORMS

Please read all documents thoroughly and keep a copy of all pages.

Contents

Client Information Form - answer all questions

Acknowledgment of Receipt of Notice of Informed Consent & Privacy Practices - Check 2 boxes at top of form. Sign and date the form. If client is a minor, parent or guardian should complete the second signature section.

Informed Consent - Read thoroughly and keep a copy for your records.

Notice of Privacy Practices - Read thoroughly and keep a copy for your records.

Client Bill of Rights - Read thoroughly and keep a copy for your records.

Letter Explaining "No Surprises Act" - Read thoroughly and keep a copy for your records.

Your Rights and Protections Against Surprise Medical Bills - Read thoroughly and keep a copy for your records.

The No Surprises Standard Notice and Consent Documents - Fill in client name on Page 2. Sign and date on Page 3.

More Details About Your Estimate - Fill out client name and enter date received on Page 4.

Awen Therapy, LLC - Jay Blevins, MS, LMFT
2564 Branch St., Suite B5, Middleton, WI 53562

Client Information Form

Name _____ Date of Birth _____

Address_____

Email address_____ Can I email you? ___Yes ___No

Home Telephone _____Can I leave a message? ___Yes ___No

Work Telephone _____ Can I leave a message? ___Yes ___No

Cell Number _____Can I leave a message? ___Yes ___No

Preferred pronouns ____She ____ He _____ They _____Other:_____

Referral Source:

What concerns bring you to see me?

What would you like to see happen as a result of coming here?

What have you tried on your own to change this issue(s)?

Have you been to see other psychotherapists?

If so, what worked successfully during the time you were with them?

Are you presently seeing any doctors and/or taking any medications? If so, please list.

Awen Therapy, LLC Jay Blevins, MS, LMFT
2564 Branch St, Suite B5
Middleton, WI 53562

Acknowledgment of Receipt of Notice of Informed Consent & Privacy Practices

You may refuse to sign this acknowledgment

I hereby acknowledge that I have received a copy of, read and understand this office's

☐ Informed Consent to Treatment Document.
☐ Privacy Practices Document

Print Name _____

Signature _____

Date _____

If Client is a Minor this form must also be signed by a parent or legal guardian.

Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Private Practice Informed Consent, but acknowledgment could not be obtained because:

□ Individual refused to sign
□ An emergency situation prevented us from obtaining acknowledgment
□ Other

Name: Date :

Awen Therapy

Informed Consent to Treatment

(As required by HIPAA and the State of Wisconsin)

This document contains important information about our professional services and business policies. We can discuss any questions you have about the procedures, and I will ask you to sign this Agreement.

When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our time together may include. You should evaluate this information along with your own opinion of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If needed, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS: Individual sessions are customarily 50 minutes, including time spent scheduling appointments and paying fees. Longer or more frequent sessions can be arranged as necessary. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

PROFESSIONAL FEES: My hourly fee is $145 for the initial evaluation session and $110 for subsequent sessions. In addition to weekly appointments, I may charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $185 per hour for preparation and $220 per hour for attendance at any legal proceeding, including travel time.

CONTACTING ME: I have a 24-hour confidential voice mail box, at which you may leave a message. I do check for messages regularly and will return calls as promptly as possible. I will make every effort to return your call within 24 hours, with the exception of noted vacation time and holidays. If you are difficult to reach, please inform me of some times when you will be available.

If you need more immediate attention, you have several options: call a friend or another member of your support network; call your psychiatrist (if you have one) or your primary care physician; contact your local county mental health center, go to the nearest emergency room, dial 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY: The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign
a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides written advance consent for activities such as those outlined below:

- I regularly consult with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. Unlicensed clinicians at are required to obtain regular supervision. If this applies to your psychotherapist, the name and phone number of the supervisor are noted in a separate agreement.
- You should be aware that I practice with other mental health professionals and in some instances, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, on-call coverage, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or your written Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about your treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS: You should be aware that, pursuant to HIPAA, I keep the clinical record on you divided into two sections. One section constitutes your Protected Health Information. It may include information such as your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone.

Except in unusual circumstances that involve danger to yourself or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, or if information is supplied to me confidentially by others, you or your legal representative may examine and/or receive a copy of your clinical record, if you request it in writing.

Because these are professional records, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of 25 cents per page (and for certain other expenses).

The second section of your file contains my psychotherapy notes (also known as process notes). These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Protected Health Information. They may also include information supplied to me confidentially by others. These psychotherapy notes are kept separate from your

Protected Health Information. Your psychotherapy notes are not available to you and cannot be sent to anyone else without your written, signed Authorization.

CLIENT RIGHTS: HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and the Notice Form. I am happy to discuss any of these rights with you.

MINORS & PARENTS: Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS: You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its
costs will be included in the claim.

INSURANCE REIMBURSEMENT: I currently accept only fee for service payable by check cash or credit card.

DISCONTINUATION OF TREATMENT: Either of us may elect to discontinue treatment at any time. It is desirable to have a final closing session if a decision to discontinue treatment is made. If the decision to discontinue is made, I will be glad to provide you with names of other referral sources if you so desire.

YOUR SIGNATURE ON THE *Acknowledgment of Receipt of Notice of Informed Consent* INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE SEEN A COPY OF THE HIPAA WISCONSIN NOTICE FORM DESCRIBED ABOVE.

Notice of Privacy Practices

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

II. I have a legal duty to safeguard your protected health information (PHI).

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is “disclosed” when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. How I may use and disclose your PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I can use and disclose your PHI without your consent for the following reasons:

- For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
- To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan (only if you use that as a payment source) to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
- For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

- Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.

I can use and disclose your PHI without your consent or authorization for the following reasons:

- When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
- When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
- When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
- When public health activities require disclosure.
- When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
- To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
- For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
- To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate and approve is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to

disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures.

You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You.

You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI.

In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made.

You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before June 5, 2008. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice.

You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail, or read it on the web.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Department of Health and Human Services, please contact me at: 2564 Branch St, Ste. B12, Middleton, WI 53562.

VII. EFFECTIVE DATE OF THIS NOTICE

Privacy Officer: **Jay Blevins, MS, LMFT**
This notice went into effect on May 23, 2010

Awen Therapy, LLC - Jay Blevins, MS, LMFT
2564 Branch St., Suite B5, Middleton, WI 53562

Client Bill of Rights

- You have the right to consult as many therapists as necessary until you find someone you feel is appropriate for you. If you are in a crisis that endangers you, it is important to connect with someone who can help you address the crisis immediately. You have the right to select another therapist, however, at any point it seems appropriate to you.
- You have the right to be treated with respect at all times and to ask your therapist questions about things that are important for you to know.
- You have the right to work with a therapist who acknowledges personal values and who will not impose them on you. You have the right to your own sexual choice, lifestyle, body size, spiritual orientation, personal values and the right to full support in finding your own way.
- You have the right to ask about your therapist's training and licensing, theoretical orientation, use of techniques, professional experience and personal therapy.
- You have the right to know your therapist's attitude regarding medication and to discuss the pros and cons of whether to take it. Only a medical doctor can prescribe medication.
- You have the right to contract with a therapist for a certain number of sessions to work on a specific goal even though many concerns are more suited to an open-ended process or your therapist may be oriented toward longer term work.
- You have the right to request that your therapist consult others in your behalf and to grant or deny permission if your therapist requests this.
- You have the right to refuse to answer any questions or give any information. It is usually helpful in the process of therapy to develop a relationship together that allows for confidential sharing of information.
- You have the right to consult with anyone else even if your present therapist does not agree with your need to do this. You have the right to consider and accept or reject all feedback, remembering that it is vital to trust your own feelings and use your own judgment.
- You have the right to stop therapy when you choose to, whether or not your therapist agrees. It is almost always worthwhile to discuss your readiness to stop therapy with your therapist; however, the decision is always yours.

You have the right to grow and change even if it makes others uncomfortable.

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January 1, 2012

Dear Client,

In compliance with the No Surprises Act that goes into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment. Please sign and date before your next appointment and return the signed document before your next appointment. If you have any questions, please don't hesitate to ask.

Thank you very much,

W. Jay Blevins, LMFT

W. Jay Blevins, LMFT
License # 908-124

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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs,such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may go to https://www.cms.gov/nosurprises, or call 1-800-985-3059.

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your healthcare provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

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You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name: W. Jay Blevins, LMFT, Awen Therapy, LLC

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

- **Review your detailed estimate.** See page four for a cost estimate for each item or service.
- **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.
- **Questions about this notice and estimate?** Call Jay Blevins at (608) 492-0069
- **Questions about your rights?** Go to https://www.cms.gov/nosurprises or call 1-800-985-3059

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

More information about your rights and protections visit:

https://www.cms.gov/nosurprises for more information about your rights under federal law.

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By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☑ W. Jay Blevins, LMFT at Awen Therapy, LLC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you.

Patient's Signature

Date and time of signature

OR

Guardian/authorized representative's signature

Print name of patient

Print name of guardian/authorized representative

Date and time of signature

Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections

Awen Therapy

Counseling for individuals, partners, and families
2564 Branch St, Ste B5, Middleton, WI 53562
(608) 492-0069 AwenTherapy.com

FEDERAL TAX ID: 27-2518945

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: W. Jay Blevins, LMFT at Awen Therapy, LLC

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

- I'm giving up some consumer billing protections under Federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ (enter date) explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress &)
	90791	Initial Diagnostic Evaluation	$145.00
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	60 mine - $110.00 90 mins - $165.00 120 mins - $220.00
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed

	Production of Records		$55 per hour
	Legal Fees		$220 per hour
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.