Kathy Wei, LCSW76613, RYT® 200, A Licensed Clinical Social Worker Corporation
26131 Marguerite Pkwy, Suite D, Mission Viejo, CA 92691
Phone: (949) 328-6696

New Client Packet

Dear Client:

Welcome to Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation. We are a registered professional corporation that provides mental health treatment and care.

Please carefully review this packet, initial at the bottom right of each page.

► Treatment Consent Form page 2-7. Sign and date on page 7.

► Notice of Private Practice page 8-14. Sign and date on page 15.

► Right to Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals page 16.

► Notice to Clients (AB630, Chapter 229, Statutes of 2019) page 16.

► Notice of Nondiscrimination [AFFORDABLE CARE ACT 45 CFR 92] page 17.

► Sign and date page 18 Acknowledgement of Receipt.

► Surprise Billing Protection Form page 19-21. Sign and date on page 21.

► Good Faith Estimate page 22-23 is available upon request.

► Complete and sign page 24 Credit Card on File.

► Complete page 25-26 Onboarding Questionnaire

If you have any questions, you may contact us at 949-328-6696.

Thank you for placing your care, and your trust, in Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation.

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TREATMENT CONSENT FORM

PSYCHOTHERAPY

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline and work on both parties for a therapeutic relationship to be an effective one.

Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived.

At your initial visit, the provider will conduct a thorough review of your current complaints and your background. By the end of the initial visit, the provider will offer preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy alone will suffice. Oftentimes, however, a combination of psychotherapy and medication management is optimal, we can provide referrals to psychiatrist or psychiatrist nurse practitioner as needed.

One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between therapist and client, so, the initial visit is also your opportunity to determine for yourself if we are the right therapist for you. If you feel that we are not well matched to your needs, we would be happy to provide you referrals to other mental health professionals.

FREQUENCY AND DURATION OF VISITS

Your initial visit lasts anywhere from sixty minutes to ninety minutes. Generally, adult initial evaluation is sixty-minute, minor initial evaluation is ninety-minute. During your initial visit, the provider and you will decide together the structure of your therapy treatment based on your presenting symptoms and your goal. Follow-up visits can be spaced out at weekly, bi-weekly or monthly intervals. Your provider and you may discuss an alternate treatment structure depending on your circumstances.

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FEES

The initial evaluation is $200.00. Follow up psychotherapy fifty-five-minute is $175. Other miscellaneous services such as filling forms, telephone correspondence, prior authorizations, court hearings, etc. requiring more than ten minutes of time, will cost $30.00 per ten minute interval.

Court Appearance and/or Legal Services: Preparation time (including submission of records) is $175 per hour. Phone calls (prorated for the time of the call) is $175 per hour. Expert witness is $350 per hour. A retainer of $1700 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. If the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1700). Clients are responsible for all attorney fees and costs incurred by the therapist as a result of the legal action.

Fees may be subject to change. If our fees are to increase, we will provide you with a thirty day notice to alert you the change.

CANCELLATIONS AND NO-SHOWS

If you must cancel or reschedule an appointment, we require at least 48-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 48-hour notice will be charged a $60.00 fee. Exceptions will be assessed on an individual basis as life circumstances can be unpredictable.

Failure to show up to an appointment, a full service fee will be charged.

PAYMENTS

We will expect payment at the beginning of each session, unless we have agreed on other arrangements. We accept cash or personal checks, and major credit cards. Checks should be made payable to "Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation" If payment is 60 days past due, we reserve the right to utilize legal resources such as collection agencies or small claims courts in order to obtain payment for our services.

INSURANCE POLICIES

We are not contracted with any insurance plans at this time.

Insurance Reimbursement: If you wish to be reimbursed for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits for out of network providers. We will provide you a paper "super bill" that you can submit to your insurance company for reimbursement. Most PPO plans will reimburse between 20%-60% of the fee.

Many insurance companies have limitations on the number and frequency of visits, and types of medications that will be covered. Occasionally, certain forms of treatment or a large number of sessions require prior authorization. If this is the case, We may need to provide information about your diagnosis, history, and treatment plan to your insurance company. Once this information is provided, it will be subject to the privacy policies of the insurance provider, and is out of our control.

NON-INVOLVEMENT IN LITIGATION

The ethics and rules of our profession prevent us from serving in a dual role of therapist and evaluator at the same time. As your therapist, we will not be conducting a formal evaluation. As such, we are unable to provide an opinion to any third party about any matter pertaining to your mental health or therapy, such as, but not limited to, your diagnosis, level of distress, cause of distress, functioning capacity, need for assistance, or disability status. Furthermore, due to the private nature of the therapeutic process, you agree that this process should be protected, and that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on our clinicians to testify in court or at any other proceeding, nor will you request that we release psychotherapy records for any legal purpose.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, our providers do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current or former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session, so we can address concerns directly.

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MEDICAL RECORDS

We are required by law to keep complete medical records. Most of our medical records will be electronic, encrypted, and under fingerprint security. Any written records including the initial consent forms, letters, outside medical records, will be kept locked.

You have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, we will charge a fee for costs of copying and mailing (see above Fee section). We may deny your request to inspect and copy in some circumstances. We may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by me; We will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

CONFIDENTIALITY

The security of your sensitive information is of utmost importance to me, and we am bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary. There are exceptions to confidentiality. These include the following:

- **Limits Imposed Voluntarily**
    - Access to Patient Information by Others in the Setting
        - Contracted agents (Billing Agents; Answering Service, Computer Guru, etc.)
    - Dual relationships that might compromise confidentiality
    - Provider contracts that allow access by third party payers (*e.g., potential audits from insurance companies*)
- **Limits Imposed by Law**
    - Laws Requiring Therapists to Initiate Disclosures without patient Consent
        - If there is a threat to the safety of others, we am required by law to take protective measures including reporting the threat to the potential victim, notifying the police, and seeking hospitalization.

  - When there is a threat of harm to yourself, we am required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.
  - If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, we am required to disclose information to seek hospitalization.
  - If you share any concerns about child abuse, elder adult abuse or dependent adult abuse, we am required by law to take protective measures to contact appropriate government agencies for investigation.
- **Possible Limitations on Confidentiality Created by the Use of Technology in the Setting**
  - Situations When Confidential Information is Stored on our Computers
  - Circumstances When Confidential Information is Transmitted Electronically
- **Possible Re-Disclosure by Others of Information a Therapist Discloses to Them**
  - Patient Application for Health/Life Insurance
  - Re-Disclosures Legally Required (e.g., Abuse investigation followed by report)
  - Re-Disclosures Legally Allowed (e.g. HIPAA-Allowed Sharing among Providers)

These situations rarely occur in an outpatient setting. If they do arise, we will do our best to discuss the situation with you before taking action. In rare circumstances we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

OUR QUALIFICATIONS

Our providers are Licensed Clinical Social Worker who are licensed to assess, diagnose, and treat psychiatric disorders across the lifespan including children, adolescents, adults, and older adults. We practice behavioral health according to the requirements and regulations of the Board of Behavioral Health in the State of California.

In addition, provider Kathy Wei, LCSW is a Registered Yoga Teacher (RYT) with Yoga Alliance, which acknowledges the completion of a 200-hours yoga teacher training with a Registered Yoga School (RYS). Kathy Wei may incorporate mindfulness movement therapy/yoga/meditation into your treatment. She teaches yoga according to the standards and regulations of Yoga Alliance USA.

PRIVATE PRACTICE

While Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation shares an office with other mental health professionals, we are in no way part of a group practice with other agencies. Our medical records are kept secure, and separate from theirs. No person operating in

our office suite will have access to your records without your written consent. We are fully responsible for the services we provide you.

If you do see one of our office-mates for other services, or if we refer you to another community therapist/physician, we may find it helpful to collaborate and coordinate your care, and this will require your written consent. Any provider to whom we refer you will be responsible for the care they provide to you.

CONTACT INFORMATION

Our voice mail at 949-328-6696 is the best way to contact us outside the office. We check our voicemail regularly. When you leave a message, please state your name clearly, your phone number(s) (even if you think I have it), reason for calling, and let us know when the best time is to contact you. Please note that we may be busy with a client but will make every effort to address your issue as soon as possible. For non-urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next business day. If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is a possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. If you need to contact us between sessions, please call 949-328-6696. Text messages and emails are only to be used for scheduling, changing or canceling appointments.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation's services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, social media policy, medical records policy, confidentiality, qualifications, the nature of practice, and contact information, and that you agree to abide by the terms stated above during the course of your therapeutic relationship with Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation provider(s).

Client or legal guardian's name (Print): _____Date: _____

Client or legal guardian's signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation (Kathy Wei, LCSW) creates and maintains treatment records that contain individually identifiable health information about you. These records are generally referred to as “medical records”, “mental health records”, “behavioral health records”, these records we create and maintain are known as Protected Health Information, or PHI. We are required by Federal and State laws to protect the privacy of your medical and behavioral health information and obtain a signed authorization by you for certain disclosures.

We are required by law to provide you with this Notice of our legal duties and privacy practices with respect to your behavioral health information. This Notice explains how we may legally use and disclose your protected health information and your rights regarding the privacy of your protected health information. We are required to follow all the terms of this notice. We reserve the right to change the provisions of this Notice and make it effective for all protected health information we maintain.

If you have any questions and/or would like additional information, you may contact us at 949-328-6696.

How We May Use and Disclose Your Protected Health Information

Your confidentiality is important to us. We are required to maintain confidentiality of our clients/patients PHI. We briefly describe these uses and disclosures of your protected health information below and provide you with some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your protected health information will fall within one of the categories. We will separately describe the ways we use and disclose substance and/or alcohol abuse information later in this Notice.

1. Payment

We may use or disclose your protected health information to permit us to bill and collect payment for the treatment and health-related services that We provide to you. For example, we may include information with a bill to your insurance company that identifies you, your diagnosis, and services provided in order to receive payment.

2. Health Oversight Activities

We may disclose your protected health information to Federal or State agencies that may conduct audits, investigations, oversight activities, and inspect health programs.

3. Victims of Abuse, Neglect, or Domestic Violence

We may disclose your protected health information to other government agencies to report suspected abuse, neglect, or domestic violence occurred to you. We will only disclose this information if you agree, if the law requires us to, or when it is necessary to protect someone from serious harm.

4. Lawsuits and Legal Actions

We may use and disclose your protected health information in response to a court or administrative order, certain subpoenas, or other legal process. We may also use and disclose PHI to the extent permitted by law without your authorization such as defending against a lawsuit or arbitration.

5. Coroners, Medical Examiners, and Funeral Directors

We may disclose your protected health information to funeral directors, coroners, and medical examiners to permit identification of a body, determine what caused the death, or for other official duties.

6. To Stop a Serious Threat to Health or Safety

We may use or disclose your protected health information if we believe it is necessary to avoid or lessen a serious threat to your health or safety or to someone else.

7. Family and Friends Involved in or Paying for Your Care

We may disclose your protected health information to a friend, family member, or any other person who is involved with your care or payment for your care. For example, you may bring a friend or family member to your appointment and treatment. You may inform us verbally or in writing if you object to disclosures to your family and friends.

8. Disclosures in Case of Disaster Relief

We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to provide needed care or to help you find members of your family.

9. Disclosures to Parents as Personal Representatives of Minors

In most cases, We may disclose your minor child's PHI to you. In some situations, however, we are permitted and sometimes required by law to deny you access to your minor child's PHI. An example of when we must deny such access, based on the type of health care, is when a minor who is 12 years old or older seeks care for a communicable disease or condition. Another situation when we must deny access to parents is when minors have adult rights to make their own health care decisions. These minors include, for example, minors who, were or are married or who have a declaration of emancipation from a court.

10. Appointment Reminders

We may use PHI that you provided us to remind you of your upcoming appointments for treatment or other health care you may need.

11. Electronic Health Records

We may use an electronic health record to store and retrieve your health information. When we enter your information into the electronic health record, it is stored in the clinical databases. We use Therapnotes, a certified HIPAA-compliant program. You can read more at Https://www.therapynotes.com/features/security/

12. Communications with Family and Others When you are Present

Sometimes a family member or other person involved in your care will be present when we am discussing your PHI with you. If you object, please tell us and we won't discuss your PHI while that person is present.

13. Communications with Family and Others When you are Not Present

There may be times when it is necessary to disclose your PHI to a family member or others involved in your care because there is an emergency or you lack the decision making capacity to agree or object. In those instances, we will use our professional judgment to determine if it is in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHwe that is directly relevant to the person's involvement with your health care. For example, we may disclose your suicidal ideation which warrants immediate attention and collaboration with your support system.

14. Required by Law

We may use and disclose your protected health information when required by Federal, State, or local law. For example, the secretary of the Department of Health and Human Services (DHHS) may review our compliance efforts which may include seeing your PHI.

15. Public Health Activities

We may use and disclose your protected health information to public health authorities or government agencies for reporting certain diseases, injuries, conditions, illnesses, and events as required by law. For example, we may disclose your medical information to a local government agency in order to assist the agency during the investigation of an outbreak of disease in the area or to comply with state laws that govern workplace safety.

16. Law Enforcement

We may disclose your protected health information to help locate or identify a missing person, suspect, or fugitive, when there is suspicion that death has occurred as a result of criminal conduct, to report a crime that happens at our office, or to report certain types of wounds, injuries, or deaths that may be the result of a crime to authorized officials such as the police, sheriff, or FBI for law enforcement purposes and in response to legal processes, such as a search warrant or court order.

17. Research

We may use and disclose your protected health information for research if approved by an Institutional Review Board (IRB). An IRB is a committee responsible, under federal law, for reviewing and approving human subjects' research to protect the safety of the participants and confidentiality of PHI.

18. Military Activity and National Security

We may use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal officials as necessary for national security and intelligence activities or for the protection of the president and other government officials and dignitaries.

19. Workers' Compensation

We may use and disclose your protected health information in order to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness. For example we may disclose your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for worker's compensation benefits.

Uses and Disclosures of Your Protected Health Information Requiring Your Written Authorization

We will obtain your written permission through an authorization for other uses and disclosures of your PHI not covered by this Notice. You may revoke the authorization in writing at any time and we will stop disclosing PHI about you for the reasons stated in your written authorization. Any disclosures made prior to the revocation are not affected by the revocation.

Your Rights Regarding Your Protected Health Information

1. Right to View and Copy Your PHI

Subject to certain exceptions, you have the right to view or get a copy of your protected health information that we maintain in records relating to your care, decisions about your care, or payment for your care. You have the right to view your records in any format that we maintain them in and you may direct them to be sent to a third party. Your request must be submitted in writing and a fee may be charged for the costs of copying, mailing, and for any other supplies used in fulfilling your request. In limited situations, we may deny some or all of your requests to see or receive copies of your records. If denied, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

2. Right to View and Copy Laboratory Test Results

You have the right to view and copy protected health information consisting of your treatment records after the appropriate authentication process has been completed. A request must be submitted in writing and a fee may be charged for the costs of copying, mailing, and for any other supplies used in fulfilling your request.

3. Right to Request an Amendment

You have the right to request that we correct or add to your record if you believe there is a mistake in your PHI or that important information is missing. The request must be in writing, explain what

corrections or additions you are requesting, and the reasons the corrections or additions should be made. We will respond in writing after reviewing your request. If we approve your request we will make the correction or addition to your PHI.

We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information in your record is correct and accurate;
- The information in your record was not created by us or the person who created it is no longer available to make the amendment; or
- The information is not part of the records you are permitted to view and copy.

If we deny your request for amendment, we will tell you why and explain your right to file a written statement of disagreement. Your statement must not exceed five pages. You must clearly tell us in writing if you want us to include your statement of disagreement along with your original amendment request and our written denial in future disclosures we make of that portion of your medical records.

4. Right to an Accounting of Disclosures

You have the right to request a list of our disclosures of your PHI. The request must be made in writing and can only include disclosures that occurred between the date of your request and up to six years before the date of your request.

The list will not include the following disclosures:

- That you provided a signed authorization for;
- To carry out treatment, payment, and health care operations;
- To family members or friends involved in your medical treatment or care;
- To jails, prisons, or law enforcement; or
- Not covered by the right to an accounting.

For electronic health records, the accounting of disclosures would also include disclosures of your PHI made to carry out treatment, payment, and health care operations.

5. Right to Request Restrictions on Uses and Disclosures of your PHI

You have the right to request a restriction or limitation on how we use or disclose your PHI for treatment, payment, or health care operation purposes. For example, you could ask us to limit the information we share with someone who is involved in your care or the payment for your care. You may also ask that we limit disclosures to your spouse. we may ask that you give us your request in writing which we will review and consider. If we agree to your request, we will not use or disclose the PHI in violation of such restriction, except if we believe this information is required by law or to provide you with necessary medical treatment or care.

We are not required to agree to your request, except that you have the right to restrict disclosures to a health plan or insurer for payment if you or someone on your behalf pays out of pocket in full for the

service at the time of the request for restriction. However, we can still disclose the information to a health plan, insurer for the purpose of treating you or if required by law.

If the services are not paid for in full and out of pocket by you or by someone on your behalf, we do not have to agree to your request to restrict uses or disclosures of PHI for treatment, payment, or health care operations purposes. We will consider all submitted requests and, if we deny your request, we will notify you in writing.

For requests to restrict your PHI for payment or health care operations purposes, please request the restriction prior to receiving services.

6. Right to Request Confidential Communications

You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number or send mail to a special address. Your request must be made in writing and must specify how or where we am to contact you. We will accommodate all reasonable requests.

If your PHI is stored electronically, you may request a copy of the records in an electronic format offered by TherapyNotes. You may also make a specific written request to transmit the electronic copy to a designated third party.

7. Right to Revoke an Authorization

You have the right to take back or revoke your written authorization to use and disclose your PHI at any time. You must let us know of your revocation in writing. If you take back your written authorization, we will stop sharing your PHI. However, we cannot take back any information already used or shared while the authorization was valid.

We are required by law to keep a record of the medical treatment you receive from us whether or not you give us written permission to use or share it. You do not have the right to have information removed from your record.

8. Right to a Paper Copy of this Notice

You have the right to receive a paper copy of this notice any time you request it.

9. Breach Notification

In the event of a breach of your unsecured PHI, we will notify you of the circumstances of the breach.

10. Right to File a Complaint

If you have any questions about this notice, your privacy rights, or believe your privacy rights have been violated, you may contact us directly at 949-328-6696.

You also have the right to file a complaint directly to the Secretary of the United States Department of Health and Human Services (DHHS) at: DHHS, Region IX Office for Civil Rights, 90 7th Street, Suite 4-100,

San Francisco, CA 94103, or call (800) 368-1019, TDD (800) 537-7697. The complaint must be filed in writing and sent by mail, fax, or electronically by e-mail and within 180 days of when you found out the violation occurred.

Our Responsibilities

We must follow the terms of this notice while it is in effect. We reserve the right to change this notice and our corporation at any time. Changes in our corporation will apply to any PHI we already have and to PHI we create or receive in the future. If we are your provider, we will mail a new notice to you if material changes are made.

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NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

The Notice of Privacy Practices is subject to change. If we change the notice, you may obtain a copy of the revised notice by contacting us at 949-328-6696.

If you have any questions about the Notice of Privacy Practices, please contact us at 949-328-6696.

I acknowledge receipt of the Notice of Privacy Practices.

Print Name: _____ Date: _____

Signature: _____
(Client/Parent/Conservator/Guardian)

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Right to Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals

THIS NOTICE DESCRIBES YOUR RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR HEALTHCARE SERVICES WILL COST.

You have the right to receive a "Good Faith Estimate" explaining how much your healthcare services will cost.

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services. You must submit a written request to Kathy Wei, LCSW in person or email to kathy.wei.lcsw@gmail.com. A good faith estimate will be provided within 3 business days upon request. For more information or questions about your right to a Good Faith Estimate, you can visit www.cms.gov/nosurprises (a separate form: Surprise Billing Protection Form, will be provided to you)

Notice to Clients (AB630, Chapter 229, Statutes of 2019)

THIS NOTICE DESCRIBES HOW YOU AND WHERE YOU CAN FILE COMPLAINT.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the board's online license verification feature by visiting www.bbs.ca.gov.

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Notice of Nondiscrimination [AFFORDABLE CARE ACT 45 CFR 92]

THIS NOTICE DESCRIBES NONEDISCRIMINATION LAWS, SERVICES WE CAN SEEK AND WHAT YOU CAN DO WHEN YOU BELIEVE YOU HAVE BEEN DISCRIMINATED AGAINST.

Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- We can seek aids and services to people with disabilities to communicate effectively with us such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- We can seek language services to people whose primary language is not English such as:
    - Qualified interpreters
    - Information written in other languages
- Let us know if you need these services, they will be provided at a fee.

If you have any difficulty obtaining these services, believe you have been discriminated against, or wish to file a grievance related to any of these services or policies, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Kathy Wei, LCSW76613, RYT® 200, A Licensed Clinical Social Worker Corporation
26131 Marguerite Pkwy, Suite D, Mission Viejo, CA 92691
Phone: (949) 328-6696

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the listed items and you have carefully reviewed them:

- Right to Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals
- Notice to Clients (AB630, Chapter 229, Statutes of 2019)
- Notice of Nondiscrimination [AFFORDABLE CARE ACT 45 CFR 92]

Above listed items are subject to change. If we make any changes to the above notices, you may obtain a copy of the revised notice by contacting us at 949-328-6696.

If you have any questions about the above Notices, please contact us at 949-328-6696.

I acknowledge receipt of the Right to Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals; Notice to Clients Notice to Clients (AB630, Chapter 229, Statutes of 2019); Notice of Nondiscrimination [AFFORDABLE CARE ACT 45 CFR 92].

Print Name: _____ Date: _____

Signature: _____
(Client/Parent/Conservator/Guardian)

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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.

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.

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See the next page for your cost estimate.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s)or facility name: Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation_____

Total cost estimate of what you may be asked to pay:	**$**

►Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.

►Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

►Questions about this notice and estimate? Call Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation at 949-328-6696

►Questions about your rights? Please visit: https://www.cms.gov/nosurprises or 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.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan. Please go to your insurance company webpage to find in-network providers.

More information about your rights and protections

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

By signing, I give up my federal consumer protections and agree to 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):

Kathy Wei, LCSW76613, RYT® 200, A Licensed Clinical Social Worker Corporation
26131 Marguerite Pkwy, Suite D, Mission Viejo, CA 92691
Phone: (949) 328-6696

- ☐ Kathy Wei, LCSW
- ☐ Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation located at 26131 Marguerite Pkwy, Suite D, Mission Viejo, CA 92691

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:

- 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 today's 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.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Print Name: _____ Date: _____

Signature: _____
(Client/Parent/Conservator/Guardian)

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

It contains important information about your rights and protections.

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GOOD FAITH ESTIMATE

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.

Patient name:_____ Date of Birth: _____

Out-of-network provider(s)or facility name: Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation
Address: 26131 Marguerite Pkwy, Suite D, Mission Viejo, CA 92691

Estimated psychotherapy (53-60 mins) treatment sessions:_____
(*Therapy successfully ends when the client has accomplished the goals mutually agreed upon with the therapist. *Treatment length is often tentative and revisited throughout the course of treatment.)

Date of service	Service Code	Description	Estimated amount to be billed
	90791	Psychiatric Diagnostic Evaluation	$200.00
	90837	Psychotherapy (53-60 mins)	$175.00
		Total estimate of what you may owe:	

Disclaimer:

This Good Faith Estimate shows the costs of psychotherapy services that are reasonably expected for you. The estimate is based on information known at the time the estimate was created. The Good Faith

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Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, you still have the right to dispute the bill.

If for any reason you are billed substantially more than the amount in your Good Faith

Estimate (which means $400 or more beyond the original estimate), you may contact your provider directly to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is Financial assistance available.

You also have the right to pursue a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

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CREDIT CARD ON FILE

Payments are due at the time of service. For your convenience, we use a HIPAA compliant credit card processing system via TherapyNotes, where you may keep a credit card on file with Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses that are due at the beginning of each session or balance that has accrued in the previous month. Please fill out your credit card information, initial all three items and sign below:

Credit card Number: _____ Expiration Date: _____

Name on the credit card: _____ CVV Code: _____

Billing Address: _____ Zip Code: _____

(Initial) _____ I agree to input my credit card information using TherapyNotes at the initial appointment.

(Initial) _____ Please charge my card for any co-pays, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses at the end of each session.

(Initial) _____ Please charge my card for all balances in full that accrue each month (30 days). Charges will be made at the beginning of each month.

I understand that by signing below, I am authorizing Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees. I understand that Kathy Wei, LCSW, A Licensed Clinical Social Worker Corporation will provide a receipt if requested by the client.

Client/Card Holder's Signature: _____ Date:_____

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ONBOARDING QUESTIONNAIRE

CLIENT INFORMATION

Client name: _____ Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female ☐ Transgender Date of Birth: _____ Age: _____

Address: _____

Phone: _____ May we leave a detailed message for you? ☐ Yes ☐ No

Email: _____ Appointment confirmation will be sent to this email

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Address: _____ Phone Number: _____

CARE QUESTIONNAIRE

How would you prefer to attend your sessions? ☐ In person session ☐ Virtual session

(In person sessions are only available on Mondays in our Mission Viejo office.)

What is the main reason you are seeking care?

_____
_____
_____

Are there any other areas you'd like to address?

_____
_____
_____

What is your goal?

_____
_____
_____

Have you seen a mental health care provider before? If yes, please provide information on the length of treatment, issues being treated for and outcome.

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_____

_____

_____

Will you authorize Kathy Wei, LCSW to communicate and coordinate care with your other providers?

☐ Yes, please complete release of information/authorization ☐ No

Please list any medical conditions (client):

_____

_____

Please list any prescription medication/doses:

_____

_____

Please list your provider who is prescribing your psychotropic medication?

_____

Will you authorize Kathy Wei, LCSW to communicate and coordinate care with your other providers?

☐ Yes, please complete release of information/authorization ☐ No

What are your scheduling preferences? (Currently accepting new clients for Mondays and Fridays).

_____

_____

How were you referred to Kathy Wei, LCSW?:

_____