Brett Fry, PsyD, PC
405 N. Wabash, Suite #1815
Chicago, Illinois 60611

CLIENT INFORMATION

Legal Name: _____ Date: _____

Preferred Name:_____Gender: _____Age: _____Date of Birth:_____

Street Address: _____ Unit # _____

City:_____ State:_____ Zip:_____

Cell Phone: _____ok to leave message? yes no

Home Phone: _____ok to leave message? yes no

Work Phone: _____ok to leave message? yes no

Email: _____Ethnicity: _____

Relationship Status: _____

Occupation: _____ Employer: _____

Referred by: _____

If client is a minor, who has guardianship? _____

Emergency Contact:_____Relationship to client: _____ Phone #:_____

INSURANCE INFORMATION (if applicable)

Insurance Company: _____

ID # _____Group #:_____

Deductible: _____ Copay/Co-ins amount (if known): _____

If different from above,
Subscriber's Name: _____

Subscriber's Address: _____

Subscriber's DOB: _____

Subscriber's Employer: _____

I authorize release of necessary information to the above insurance company, Availity L.L.C., and Office Ally, Inc. to process claim forms. I authorize Brett Fry, Psy.D. to obtain authorization for my sessions (if applicable). I authorize payment of medical benefits to Brett Fry, Psy.D. when applicable. I understand that I am responsible for all charges not covered by my insurance carrier. Consent valid for one year from the date of signature.

_____ _____
Signature of Client (if client is an adult) Date

_____ _____
Signature of Client (if client is a minor, age 12-17) Date

_____ _____
Signature of Legal Guardian of minor client Date

You may be charged for appointments cancelled or broken without 24 hours advance notice. Insurance cannot be billed for this type of service, therefore the client is responsible for the payment/fee.

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CLIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Dr. Brett Fry. I authorize the mental health care services deemed necessary or advisable by Dr. Fry to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the practice. I authorize Dr. Fry to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dr. Fry may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. This authorization allows for release of information to Office Ally, Inc. and Availity, L.L.C. I understand that if Dr. Fry is to die or become incapacitated, his Professional Executor may take control of records and contact patients.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I understand that I am financially responsible to Dr. Fry for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees.

PRIVACY POLICY. I acknowledge having received the HIPAA Notice Form (Dr. Fry's *Notice of Privacy Practices*). My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Notice. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Dr. Fry has already made disclosures with my prior consent.

OUTPATIENT SERVICES CONTRACT. I have read and understand the information in Dr. Fry's *Outpatient Services Contract*, and I agree to abide by its terms during our professional relationship.

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES. Telehealth has become an increasingly utilized modality of treatment. It offers particular benefits (convenience, increased access), and it comes with some risks. The same rules and laws of confidentiality that exist for in-person treatment also apply to telehealth services, but there are some risks of confidentiality that differ from in-person sessions. It is also important to keep in mind that insurance coverage for telehealth services may not be guaranteed. Prior to starting telehealth services, we agree to the following:

- Sessions will not be recorded without the permission from the others person(s).
- We agree to use the phone or the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- For video sessions, you need to use a webcam or smartphone and the necessary technology.

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- It is important to be in a quiet, private space that is free of distractions during sessions. Client acknowledges risk to privacy when they are not in a private location.
- It is important to use a secure internet connection rather than public/free Wi-Fi. Client acknowledges risk to privacy/confidentiality when using public/free Wi-Fi.
- It is important to be on time. Typical cancelation policies will apply. If you need to cancel or change your tele-appointment, you must notify me in advance.
- We need a back-up plan (e.g., a way to contact you) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact, and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name: Brett Fry, PsyD ***Psychologist signature:***_____

Patient name (print): _____ ***Patient signature:***_____

Date: _____

Legal Representative (if necessary): _____

Signature of Legal Representative (if necessary):_____

Witness Signature: _____

Client unable to sign. Verbal consent given. Reason: _____

Consent valid for one year from the date of form completion.

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INTAKE FORM

Presenting Issues:

Have you been in therapy before? yes no

If yes, describe therapy experiences (when in therapy, issues addressed, diagnoses received, was therapy helpful, etc.):

Occupation/Employer:

Describe any issues or problems with work:

Education:

Describe any issues or problems with school:

Original family constellation (parents, siblings):

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Current living situation (independent, roommates, family):

Describe any significant medical/physical health issues:

Current medications:

Social relationships:

Romantic relationships:

Friendships:

Describe any body image issues/concerns:

Describe how your mood has been recently (happy, sad, angry, anxious, etc.):

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Describe anxiety/stress level:

Describe alcohol/drug use:

(Substances used, frequency, amount, history)

Ever hear or see things that other people don't? yes no

If yes, describe:

Family history of mental health issues:

Describe any history of self-harm and/or suicidal behavior:

Describe any history of aggression and/or violent behavior:

Recreational interests/hobbies:

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions you might have.

About Psychotherapy

Psychotherapy is not easy to describe in general statements. It varies depending on the personalities of the therapist and patient, and on the particular problems brought forward. There are several different methods I may use to deal with the problems that you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. Therapy can be most successful when you think about things or perhaps work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy can involve discussing unpleasant aspects of life, you may experience uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

As we work together, we will assess your needs. You should evaluate and consider your own opinions about whether you feel comfortable working with me. Therapy involves a commitment of time, energy, and money, so you should be careful about selecting a therapist. If you have questions about my practice or about therapy, you may bring them up whenever they arise. If, for whatever reason, you decide not to work with me, I can attempt to help you find another mental health professional who may be better able to meet your needs.

Confidentiality

In general, the privacy of communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your permission. However, there are a few exceptions, including:

1) If I have reasonable cause to believe that a child, elderly person, or disabled person is being abused or neglected, I must report this information to authorities and/or the appropriate state agency.

2) If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police and/or FOID, or seeking hospitalization for the patient. If the patient threatens to harm themselves, I may be obligated to seek hospitalization for them or to contact family members or others who can help provide protection. If a patient is unstable and/or potentially dangerous, I may need to contact FOID.

3) In some legal proceedings, a judge may order my testimony if they determine that the issues demand it.

I may occasionally find it helpful to consult with other professionals about my ongoing work. This never involves your name or specifics through which you might be identified—I make every effort to avoid revealing the identity of my patient. If you don't object, I will not tell you about these consultations unless I feel it is important to our work together. Please be aware that if I were to die or become incapacitated, my Professional Executor may take control of records and may contact my patients.

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. I will be happy to discuss these issues with you, but formal legal advice may be needed because the laws governing confidentiality are complex, and I am not an attorney.

Appointments

We will usually meet for weekly sessions at an agreed time. For individual sessions, you will typically be expected to provide payment unless you provide 24 hours advanced notice of cancellation. If you are paying through insurance, your insurance may not cover this charge, so it will be your responsibility. For group therapy sessions, you are expected to provide payment whenever the group meets (whenever the group therapist runs group at the agreed time), whether you attend or not. (The 24 hour cancellation policy does not apply to group sessions.)

Fees and Payment

My current fee for individual psychotherapy is $225, and initial consultations/interviews cost $250. My fee for couples therapy is $250, and my fee for group therapy is $60. (In certain circumstances, negotiating an adjusted fee may be an option.) Missed individual sessions and late cancellations (without a prior cancellation notice 24 hours in advance) will be charged.

In addition to weekly appointments, I typically charge my fee for other professional services you may need, though I may break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, telephone conversations lasting longer than 15 minutes, or 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 my professional time even if I am called to testify by another party.

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You will be expected to pay for each session at the time it is held unless we agree otherwise, or if you have insurance coverage which requires another arrangement. Payment schedules for other professional services should be agreed on when they are requested. If there are any concerns regarding payment, please bring it to my attention.

If an unpaid balance remains outstanding for more than 60 days and arrangements for payment have not been agreed upon, your account may be turned over to a collection agency or addressed through small claims court. In most collection situations, the only information I release regarding treatment is your name, the nature of services provided, and the amount due.

Health Insurance Coverage (if applicable)

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of my fees. It is important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, please call your plan administrator. Of course I will provide you with whatever information I can based on my experience, and I will be happy to help you understand the information you receive from your insurance company. It is important to remember that insurance may not cover telehealth services (i.e., phone or video sessions).

Insurance benefits have become quite complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMO’s and PPO’s sometimes require authorization before they provide reimbursement for mental health services. These plans may be limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot may be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

Most insurance companies require you to authorize me to provide them with clinical information. Usually, insurance companies request that I provide a clinical diagnosis. Sometimes insurance companies will also request additional clinical information such as dates of appointments, treatment plans or summaries, or in rare cases, copies of the entire record. I can provide you with a copy or summary of any report I submit, if you request it. Please understand that insurance companies claim to keep their records confidential, but I have no control over how insurance companies handle their records.

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Professional Records

You will be asked to register in my portal system through Patient Ally (of Office Ally, Inc.) This will allow for us to exchange confidential documents and forms throughout your treatment. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients may be charged an appropriate fee for any professional time spent in responding to information requests.

Minors

If you are under eighteen years of age, please be aware that your parents/caretakers are allowed to hear about your treatment. Typically, I will provide your parents with general information about our work together, unless I feel there is a high risk situation. In this case, I will notify them of my concern. Patients under twelve years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between twelve and eighteen can not examine their child's records unless the child consents and unless I find that there are no compelling reasons for denying the access. When treatment is complete, I can provide your parents with a summary of your treatment. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Telehealth

In recent years, telehealth (treatment via video or telephone) has become a viable option. Depending on your clinical needs and other factors, telehealth may be a modality that we utilize. If we decide that telehealth sessions are appropriate, it is important that you let me know in advance if you will be travelling since there are limitations to interstate telehealth. Please be aware that there may be variations in states' confidentiality policies, and that insurance coverage for telehealth is not always guaranteed.

Contacting Me

I am not always immediately available by phone. When I am unavailable, your call should be answered by my confidential voice mail, and you may always leave a message for me. Please note that it is helpful for me to know optimal times to reach you. Emails and texts can be less dependable—I may not receive them, and I can't guarantee that I will be able to respond promptly, if at all, to them. Please be aware that I can not guarantee confidentiality of emails and texts (because of potential hackers). If you must use email or texts, it is best to keep communication limited and non-clinical in nature. Please note that I typically respond to non-urgent voice mails, texts, and emails during my work week. If you are unable to reach me, and your situation is urgent and you feel you cannot wait for me to get back to you, contact your family physician, contact the 24-hour crisis line at Northwestern Hospital (802)524-6554, call 911, 988, or go to the nearest hospital emergency room. If I will be unavailable for an extended time, I can provide you with the name of a colleague to contact if necessary. Lastly, please note that I do not engage with clients through social media.

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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 INFORATION. PLEASE REVIEW IT CAREFULLY.

I respect client confidentiality and only release medical information about you in accordance with the Illinois and federal laws. This notice describes my policies related to the use of the records of your care generated by my practice. If you have any questions about this policy or your rights contact me at (773)573-3612.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information Disclosed With Your Consent. In order to effectively provide you care, there are times when I will need to share your medical information with others beyond my practice. In such cases I will obtain an authorization from you before releasing this information. These include:

Treatment: I may use or disclose medical information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside my practice that I am consulting with or referring you to.

Payment: Information may be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: I may use information about you to coordinate my business activities. This may include setting up your appointments, reviewing your care, and business-related matters such as audits and administrative duties.

I will also obtain an authorization from you before using or disclosing:
· PHI in a way that is not described in this Notice.
· Psychotherapy notes
· PHI for marketing purposes
· PHI in a way that is considered a sale of PHI

Information Disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care: I may contact you regarding scheduling of appointments or to provide information that be of interest to you.

As Required by Law: This would include situations where I have a subpoena, court order, or am mandated to provide public health information, such as suspected child abuse or neglect, elder abuse, or institutional abuse.

Governmental Requirements: I may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. I am also required to share information, if requested, with the Department of Health and Human Services to determine my compliance with federal laws related to health care.

Criminal Activity or Danger: If a crime is committed on the premises or against personnel, I may share information with law enforcement to apprehend the criminal. I also have the right to disclose information to appropriate sources when I believe an immediate danger may occur to someone.

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Information about you may be disclosed without your consent when the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

CLIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record: You are entitled to inspect the medical record my practice has generated about you. I may charge you a reasonable fee for copying and mailing your record.

Release of Records: You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction of Records: You may ask me not to use or disclose part of the medical information. This request must be in writing. I am not required to agree to your request if I believe it is in your best interest to permit use and disclosure of the information.

Contacting You: You may request that I send information to another address or by alternative means. I will honor such request as long as it is reasonable and I am assured it is correct. I have a right to verify that the payment information you are providing is correct.

Amending Record: If you believe that something in your record is incorrect or incomplete, you may request that I amend it. To do this, ask me for the *Request to Amend Health Information* form. In certain cases, I may deny your request. If I deny your request for an amendment you have a right to file a statement that you disagree with me. I will then file my response, and your statement and my response will be added to your record.

Accounting for Disclosures: You may request an accounting of any disclosures I have made related to your medical information, except for information I used for treatment, payment, or health care operations purposes or that I shared with you or your family, or information that you gave me specific consent to release. It also excludes information I was required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to me. I will notify you of the cost involved in preparing this.

Questions and Complaints: If you have any questions, concerns or complaints, you may discuss them with me. I will provide a copy of this Policy upon request. You also may complain to the Illinois Department of Human Services if you believe I have violated your Privacy rights. I will not retaliate against you for filing a complaint.

Changes in Policy: I reserve the right to change this Privacy Policy based on the needs of the practice and changes in state and federal laws.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Right to Opt out of Fundraising Communications: You have a right to decide that you would not like to be included in fundraising communications that I may send out.

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You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

  Make sure to save a copy or picture of your Good Faith Estimate.
  For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith 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, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed 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 may also start 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. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call the U.S. Department of Health and Human Services.

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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NO SURPRISES ACT/GOOD FAITH ESTIMATE

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more.

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

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your Good Faith Estimate.

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GOOD FAITH ESTIMATE

Date: _____

Estimate of what you could pay if you give up your protections:

Patient Name: _____ **Date of Birth**: _____

Out-of-network provider(s) or facility name:

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Chicago, IL 60611
(773) 573-3612
Tax ID # 45-3880199
Billing Provider NPI # 1306116074
Rendering Provider NPI # 1326051012

The following is a detailed list of expected charges for psychotherapy sessions (typically reoccurring), beginning (date if scheduled):_____:

SERVICE:	***CPT code:***	***INITIAL DIAGNOSTIC IMPRESSIONS:***	***EXPECTED COST:***
Diagnostic evaluation (in office or telehealth)	90791		$250 per session
Individual psychotherapy (in office or telehealth)	90837		$225 per session
Individual psychotherapy (in office or telehealth)	90834		$225 per session

Note that psychotherapy treatment may last anywhere from one session to 52 weekly sessions in a year (unless a different frequency of visits is agreed upon). Therefore, the estimation of total cost for a year may lie anywhere from _____ to _____ . The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

The amount listed 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 get more information about how much you'll be asked to pay, and if your plan will pay any portion of these costs. You also can ask about what's covered under your plan and your provider options. You may be able to get the items or services described in this notice from providers who are in-network with your health plan.

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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 the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options
For more information about your legal rights regarding the No Surprises Act, visit www.cms.gov/nosurprises/consumers for or call 1-800-985-3059.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from Dr. Brett Fry. With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured.

I also acknowledge that:
• I'm giving up some consumer billing protections under federal law.
• I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
• I was given a written notice on (date)_____ that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed 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 of the 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. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network. Take a picture and/or keep a copy of this form. It contains important information about your rights and protections.

(X)_____or _____
Patient's signature Guardian/authorized representative's signature

(X)_____ _____
Print name of patient Print name of guardian/authorized representative

(X)_____ _____
Date and time of signature Date and time of signature