Center for Healthier Relationships,
Individuals, & Sexualities

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 at your next appointment. If you have any questions, please don’t hesitate to ask.

Sincerely,

Christopher Wilson, PhD, LMFT, CST

Center for Healthier Relationships, Individuals, & Sexualities

The No Surprise Act, Standard Notice and Consent

No 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 are not required to sign this form and should nOt sign it if you did not 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 would like assistance with this document, ask your provider. Take a picture and/or keep a copy of this form for your records.

Why You Are Receiving this Form:

You're getting this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not 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 are 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.

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Ask your health care 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. See the next page for your cost estimate.

Good Faith Estimate

The amount below is only an estimate. This estimate shows the full estimated costs services listed. It does not include any information about what your health plan may cover. **This means that the final cost of services may be different than the estimate. Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

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Session fee, for a 50 minute session, is $_____. Session fees are expected to be collected at time of service. A client will only be charged at a later date in the event the payment does not go through on original date of service and payment method must be updated. Your therapist will collaborate with you to discuss session frequency, including plan to decrease frequency as needed. Cancelations with less than 24 hours notice are subject to potential full fee payment. Clients will be charged on date of service if no show/no call or late cancelation. Payment may be made through IvyPay app, cash, or check.

Services offered are: intake assessment (CPT Code 90791 or 90791-95), individual therapy (CPT Code 90834 or 90834-95) or couples/family therapy (CPT Code 90847 or 90847-95). Therapist may also charge at 15 minute increments for services such as Online Digital Evaluation & Management (Responding to Emails & Texts) or Telephone Assessment & Management (Case Coordination with other providers) when they take over 15 minutes in duration. Session rate for services is the same.

More information about your rights and protections:

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise- billing-providers-facilities-health.pdf 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 acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that: I am 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 written notice on _____ explaining that my provider or facility is not 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 do not have to sign this form, but if you do not sign, this provider or facility will not treat you.

Patient's Signature _____

Print Name of Patient Date & Time of Signature _____

or Guardian/Authorized Representative' Signature _____

Print Name of Guardian/Authorized Representative Date & Time of Signature

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