**Standard Notice and Consent**

**Under the “No Surprises Act,” Effective January 1, 2022 [H.R. 133]**

**Surprise Billing Protection Form**

**This document describes your protections against unexpected medical bills. It also asks if 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 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 are 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 does not 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 are 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 are 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 below for your cost estimate.

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

**Client name:**

**Out-of-network provider(s)or facility name:** Suzanne Davis, LPC, RPT-S at Davis Counseling & Play Therapy Center, PLLC

**Total cost estimate of what you may be asked to pay for one year or 52 weeks (as identified in the “Good Faith Estimate for Health Care Items and Services”):** $11,300-11,400\*

**\*Please Note:** The sliding pay fee scale option is not calculated into the “total cost estimate” as indicated, and not all counseling services for the duration/frequency of counseling treatment will be applicable over a year or 52 weeks (see page 4 for details). **The amount indicated in the total cost estimate is only an estimate.**

►**Review your detailed estimate.** See page 4 for a cost estimate for each item or service you will receive.

►**Call your health care plan or health care insurance.** Your plan may have better information about how much you’ll 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?** Contact Suzanne Davis at 757-533-2266 or email at sdavis@daviscounselingandplaytherapy.hush.com.

►**Questions about your rights?** Contact 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 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:**

You can get the items or services described in this notice from in-network providers within your health care plan by contacting your health care insurance company.

**More information about your rights and protections:**

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

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

With my signature, I am agreeing to receive the items or services from:

☐ Suzanne Davis, LPC, RPT-S at Davis Counseling & Play Therapy Center, PLLC

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

• I am 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 (e.g., “Good Faith Estimate for Health Care Items and Services”) 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 or during 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 is in your health plan’s network.**

or

Client’s signature Guardian/authorized representative’s signature

Printed name of client Print name of guardian/authorized representative

Date and time of signature Date and time of signature

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

**It contains important information about your rights and protections.**

**More details about your total cost estimate**

**Client name:**

**Out-of-network provider(s)or facility name:** Suzanne Davis, LPC, RPT-S at Davis Counseling & Play Therapy Center, PLLC

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 if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Service\*** | **Name of Provider or Facility** | **Service Code** | **Description** | **Estimated amount to be billed (per session fee)** |
|  | Suzanne Davis, LPC,  RPT-S | 90791 | Initial evaluation for counseling services/Intake session | $100 |
|  | Suzanne Davis, LPC,  RPT-S | 90837/  90837-GT (95) | 60-minutes counseling session (includes individual counseling sessions for child/adolescent/adults)/  Telehealth 60-minutes counseling session | $100 |
|  | Suzanne Davis, LPC,  RPT-S | 90846/  90846-GT (95) | Family session without patient (includes individual and/or joint parent sessions/co-parenting for minor clients)/ Telehealth family session without patient | $100 |
|  | Suzanne Davis, LPC,  RPT-S | 90847 | Family session with patient/Family session | $100 |
|  | Suzanne Davis, LPC,  RPT-S | 90847 | Marital/Couples counseling | $150 |

\***Date of Service:** The date of service indicates the date in which the services listed (if applicable) occurred at the current full flat fee at the listed amount to be billed at the time of the service rendered, and the estimated amount does not include the sliding pay fee scale option should it be implemented.