No Surprise Act/Good Faith Estimate

The rules:

A. These rules apply to Health Care Providers, which is defined as "a physician or other health care provider who is acting within the scope of practice of that person's license or certification under applicable State law..." See 45 CFR 149.610(a)(2)(viii)

B. For the purposes of this law, uninsured patients/clients are treated the same as self-paying (i.e., fee for service) patients/clients. See 45 CFR 149.610(a)(2)(xiii)

C. Providers must determine if a patient/client is self-paying or uninsured by asking the client if (1) they are enrolled in a health plan, and if so, if he/she is seeking to submit claims for the provider's service with the patient's plan/insurer.

D. Providers must also inform all potential clients of the availability of a good faith estimate of expected charges upon scheduling an item or service or upon request. There are three requirements for how you do this:

a. You must inform people via written notice "in a clear and understandable manner, prominently displayed (and easily searchable from a public search engine)" on your website.

b. Prominently displayed in your office

c. On-site where scheduling and inquiries about costs occur.

E. Any inquiry regarding potential costs must be considered a request for a good faith estimate.

F. If you are working with someone else or another facility, and someone makes a request or inquiry concerning potential costs, then (1) within one business day you need to contact the other person or facility who are reasonably likely to provide services and have them provide you with good faith estimate information (2) give them a deadline to provide you with the required breakdown of estimates of costs.

G. Here are your deadlines for providing the good faith estimates to self-pay individuals:

. If the service is scheduled at least three business days in advance, then you have to provide the estimate no later than one business day after the date of the scheduling

a. If the service is scheduled at least ten business days in advance, then you have to provide the estimate no later than three business days after the date of the scheduling

b. When a good faith estimate is requested by a self-pay individual, then you have to provide the estimate no later than three business days after the date of the request.

H. If someone has scheduled a service and received a good faith estimate from you, but you come to believe that there will be changes to the scope of what you have estimated, then you have to provide a new good faith estimate no later than one day before the services are scheduled to be furnished.

I. If you are providing recurring services (e.g., weekly recurring services, basically what most psychotherapists do), you can issue one good faith estimate, but only if the following requirements are both met:

. The recurring items or services must include, in a clear and understandable manner, the expected scope of recurring services (such as timeframes, frequency, and total number of recurring services; **and**

a. The scope of the recurring services cannot exceed 12 months. If the services go beyond 12 months you'll need to provide a new good faith estimate and communicate to the self-pay individual what, if anything, has changed with the new estimate.

J. If you issue a good faith estimate, the estimate you issue is part of the patient/client's healthcare record and must be maintained just like any other part of the patient/client's healthcare record. It must be kept for at least 6 years and a copy of all past estimates previously furnished within the last 6 years must be provided once again upon request of the patient/client.

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Considering all of these rules, here are the steps you need to take if you are an independent practitioner seeing a patient/client on a fee-for-service or private pay basis, and are not working with other clinicians or providers to provide the service:

Step 1: Post a public notice on your website, in your office, and at the location where scheduling/service inquiries take place, notifying all self-pay individuals of the availability of a good faith estimate of expected charges upon scheduling or upon request. The format of the sample language should be clear, understandable, and easy to read. It shouldn't be hidden, buried, or unsearchable from a search engine. It must be made available in accessible formats and in a language understandable to the inquiring individual. Here is an example of the language you can use in your public notice:

> You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cos
>
> 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.

Step 2: Whenever an individual asks you about the services you provide, ask him/her/them if he/she/they are enrolled in a group health plan they are using for your services; have group/individual health insurance coverage; and/or are seeking to have a claim for your services submitted to his/her/their carrier (which includes Medicare, Medicaid, IHS, VA, Tricare, etc.)? If the answer is "yes," and/or they will pay of pocket for your services, do not use this form or these instructions.

Step 3: If the answer to the question you pose in Step 2 (above) is "no" (or if the individual clearly communicates in some other way that they do not intend to submit the claim), then you must tell the individual orally about the availability of a good faith estimate.

Step 4: Any discussion or inquiry regarding potential costs of services or items must be considered a request for a good faith estimate. In other words, they don't need to ask, explicitly, for a "good faith estimate." Following any discussion or inquiry, the individual needs to receive the good faith estimate within the time frame described in Rule G, above. To be safe, it's a good idea to get used to providing these good faith estimates as a matter of course and on a regular basis.

Step 5: Provide the good faith estimate and attach it to the individual's record. It needs to be provided in written format (either electronically or on paper), though you can also provide the info orally if the individual requests. Document the provision of the good faith estimate and how it was provided. Maintain the good faith estimate you've provided just like any other piece of clinical documentation, for at least 6 years. If the individual asks for estimates previously provided to them, you have to provide all of the estimates you've kept that they wish to review. (Do you have to keep a copy of all good faith notices for individuals you don't end up seeing? The answer to that is unclear, but to be safe it would be reasonable to keep a catchall file of all good faith estimates provided, which didn't end up being attached to a client's record.)

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. You can choose to receive 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. 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.

If you sign this form, you may pay more than you might if this service is provided by your health plan 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 clinician was assigned to you with no opportunity for you to make requests for a clinician. Before deciding whether to sign this form or request care from this office, you can (and should) 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 office or another one.
- Though it is impossible to predict with certainty how many psychotherapy sessions will be necessary or helpful to you, what follows will be an estimate of what you might expect if the services you are requesting occur on a regularly scheduled basis. Your treatment needs and your care recommendations might change, depending on how your needs and symptoms change.
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  See the next page for your cost estimate.

Estimate of what you could pay

Patient name:

Patient DOB:

Clinician/Provider Name	Clinician/Facility NPI	Clinician/Facility EIN or Tax ID

Location where services will be provided:

Total cost estimate of what you may be asked to pay:	
<u>If</u> services are recurring, anticipated frequency of the above cost estimate (weekly, monthly, twice weekly, etc.):	

►**Review your detailed estimate. See the following pages 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 me at this number: ________________**

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

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

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially an excess of the expected charges included in the good faith estimate, as specified in 45 CFR §149.620. You can learn more about how to initiate the patient-provider dispute process by visiting https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of healthcare services furnished to an uninsured or self-pay individual.

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):

☐ [*Provider's name*]

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 this written notice on ________________ [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 received 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.

____ Patient's signature

____ Print name of patient

____________________________ Date and time of signature

____ Guardian/authorized representative's signature

____ Print name of guardian/authorized representative

____________________________ 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 estimate

Patient name:

Clinician/Provider name:

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. You are not required to obtain the items or services listed below, and you are also not required to receive them from me.

Description of Services:

You are requesting treatment services, which are offered by me or this facility on a repeating basis, including additional items you may request such as phone contact, electronic correspondence, and/or administrative tasks upon request and where clinically indicated. If there are other items or services that I recommend that are not included in the estimate, below, they must be scheduled and/or requested separately, at which point I will give you another good faith estimate for those services.

Providing these types of estimates for psychotherapy can be challenging because the length of psychotherapy treatment depends on what we discover and agree upon during the course of our meetings. Some individuals receive psychotherapy or other treatment services for a short period of time, whereas others remain in treatment for a much longer period of time. Because of this variability, I am offering you this estimate that includes my per-week fees for the services you are requesting. Other services, such as calls or other forms of between-session services, are common but occur on an as-needed basis so those fees are not included in the total for this good faith estimate, but they are listed, below, so that you can understand and plan for costs. If our work together utilizes these additional services on a consistent basis I may reissue this good faith estimate to include those additional costs.

Important: If there are other items or services that will require separate scheduling and that are expected to occur before or following the items requested below, separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services, and those estimates (if applicable) are not reflected, below. Additional items or services I/we may recommend as part of your course of care are not included in this good faith estimate; they must be scheduled or requested separately.

Date of Service/Frequency (if ongoing)	**Type of Service/CPT Code (if applicable)**	**Description**	**Estimated Amount To Be Billed**

Total Estimate Of What You May Owe Per Week:	