Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

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 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 may owe the full costs billed for items and services received.
- You are giving up your protection under the law
- 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.

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

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.

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

Estimate of what you could pay:
Patient name:

Patient date of birth:

Out of network provider: Stacy H. Kaplan, LICSW

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

►**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?** Contact Stacy H. Kaplan, LICSW at (857) 919-1679 or skaplan.licsw@verizon.net

►**Questions about your rights?** Contact Office of the Secretary of the Commonwealth of Massachusetts:

Toll Free: 1-800-392-6090 (within Massachusetts only)

Telephone: 617-727-7030
Fax: 617-742-4528
E-mail: cis@sec.state.ma.us

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.

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

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:

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.

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 Stacy H. Kaplan, LICSW

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 January 7, 2022, 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
- 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

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

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.

_____ or _____

Patient's signature | Guardian/authorized representative signature

_____ _____

Print name of patient | Print name of guardian/ auth. 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 estimate:

Patient name:

Patient date of birth:

Out-of-network provider name: Stacy H. Kaplan, LICSW

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.

Estimate of what you could pay

Patient name:

Tax ID # 27-4834851 **NPI #1881817138**

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

Out-of-network provider: Stacy H. Kaplan, LICSW

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. *GFE is only an estimate of items/services reasonably expected to be furnished at the time and final items, services or charges may differ

Please see the breakdown of possible fees below:

Expected Primary Service:
Based on initial information provided, patient can plan to attend _____ 45 minute therapy sessions (which could be individual therapy, family therapy etc) at a regular frequency of _____for the next year (or more). This primary service is expected to cost _____ per session, as discussed with your provider already.

Based on the primary service patient can expect to pay a total of _____.

Applicable Diagnostic Codes*:
*While proper diagnosis requires careful and skilled assessment by your provider, new legislation is requiring that diagnostic codes be included on Good Faith Estimates. The following diagnoses are possible for the patient based on brief consultation with patient/patient guardian. The diagnostic code(s) below should not be considered a diagnosis on medical record and will be adjusted as needed after the appropriate clinical evaluation process has been completed by provider.

BELOW ARE COMMONLY USED DX - CONSULT DSM FOR FURTHER CONSIDERATIONS:
ADHD
F90.2 ADHD, Combined presentation
F90.0 ADHD, predominantly inattentive presentation
F90.1 ADHD, predominantly hyperactive/impulsive presentation
F90.8 Other Specified Attention-Deficit/Hyperactivity Disorder
F90.9 Unspecified Attention-Deficit/Hyperactivity Disorder
DEPRESSIVE DISORDERS
F32.0 Major Depressive Disorder, Single Episode Mild (.1 Moderate; .2 Severe; .3 with psychotic features; .4 In partial remission; .5 in full remission; .9 unspecified)
F33.0 Major Depressive Disorder, Recurrent Episode Mild (.1 Moderate; .2 Severe; .3 with psychotic features; .4 In partial remission; .5 in full remission; .9 unspecified)

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

F34.1 Persistent Depressive Episode (Dysthymia)
F32.8 Other Specified Depressive Disorder
F32.9 Unspecified Depressive Disorder

ANXIETY DISORDERS

F93.0 Separation Anxiety Disorder
F40.10 Social Anxiety Disorder
F41.0 Panic Disorder
F41.1 Generalized Anxiety Disorder
F41.8 Other Specified Anxiety Disorder
F41.9 Unspecified Anxiety Disorder

OBSESSIVE COMPULSIVE DISORDERS

F42 Obsessive-Compulsive Disorder (can also be Other Specified and Unspecified

TRAUMA AND STRESS RELATED DISORDERS

F43.10 Posttraumatic Stress Disorder
F43.0 Acute Stress Disorder
F43.21 Adjustment Disorder with depressed mood (.22 with anxiety; .23 with mixed anxiety and depressed mood; .24 with disturbance of conduct; .25 with mixed disturbance of emotions and conduct; .20 unspecified)

OTHER MENTAL DISORDERS

F99 Other Specified Mental Disorder
F99 Unspecified Mental Disorder

Expected CPT Codes and Charges:

90791 Diagnostic Evaluation	$200.00
90832 Individual Therapy 30 min (actually 16-37 min)	$150.00
90834 Individual Therapy 45 min (actually 37-52 min)	$175.00
90837 Individual Therapy 60 min (actually 53+ min)	$200.00
90839 Crisis Session 60 min (actually 30-74 min)	$200.00
90839 Crisis Session each additional 30 min	$100.00
90846 Family Therapy without Patient	$175.00
90847 Family Therapy with Patient	$175.00
90899 Preparation of Reports billed in 15 min increments	$50.00

Additional Services That May Require Additional Scheduling:

90832 Individual Therapy 30 min (actually 16-37 min)	$150.00
90834 Individual Therapy 45 min (actually 37-52 min)	$175.00
90837 Individual Therapy 60 min (actually 53+ min)	$200.00
90839 Crisis Session 60 min (actually 30-74 min)	$200.00

Tax ID # 27-4834851 **NPI #1881817138**

Stacy H. Kaplan, LICSW
MA License # 111111
825 Beacon Street, Suite 19
Newton, MA 02459
(857) 919-1679 skaplan.licsw@verizon.net
www.newtontherapy.com

90839 Crisis Session each additional 30 min	$100.00
90846 Family Therapy without Patient	$175.00
90847 Family Therapy with Patient	$175.00
90899 Preparation of Reports billed in 15 min increments	$50.00

Provider Information:
Provider Name: Stacy H. Kaplan, LICSW
Provider TIN: 27-4834851
Provider NPI: 1881817138