Pathway Therapy Services, PLLC

Disclosure of Protections Against Surprise Medical Bills under "No Surprise Act"

In compliance with the **No Surprises Act** that went into effect January 1, 2022, providers are required to notify all healthcare consumers of your Federal rights and protections against "surprise billing".

This Act requires that providers notify you of your federally protected rights to receive a notification when services are rendered by a non-participating provider and provide options to receive care from an in-network provider if one is available.

You are 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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the

difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing."This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can not balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also

are not required to get care out-of-network. You can choose a provider or facility
in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

  - Cover emergency services by out-of-network providers.

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

By eSigning this section, I acknowledge that I have read and understood my federal rights under the No Surprise Act. I am choosing to work with this provider who is NOT in network with my insurance plan and therefore I will be responsible for the full costs of care as outlined below.

Good Faith Estimate for Health Care Items and Services

Pathway Therapy Services, PLLC

Client Information:

First Name:

Middle name:

Last Name:

DOB:

Client Contact Information:

Street or PO Box:

City

State

Zip

Phone

Primary service for item requested/scheduled:

Individual Therapy

or

Couples/Family Therapy

Client primary Diagnosis: Diagnosis: Z65.9 Unspecified Problems related to Unspecified Psychosocial Circumstances. (*Disclaimer: above diagnosis is for the purposes of providing this Good Faith Estimate. Diagnosis will change after the initial evaluation. The Diagnosis does not impact the cost of appointments.)*

Dates of Service: To Be Scheduled

Date of good faith estimate:

Provider Rates: Telehealth Only

The following is a detailed list of expected charges. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

CPT Code	Modifier	Services	duration	Frequency	Price
90791	95 (Telehealth)	Psychiatric Diagnostic Evaluation	55 minutes	1 session required by the provider. any additional Evaluation appointments per the request of the client	$160 per evaluation
90837	95 (Telehealth)	Psychotherapy- Individual	55 minutes	Based on recommendation of medical necessity, or per request of client. Most often 1x per week. Other options include every other week or monthly. Occasionally due to increase of symptoms and decrease in functioning 2x per week can be approved by the provider and with consent of client until symptoms and functioning improve.	$140- per session
90834	95 (Telehealth)	Psychotherapy- Individual	45 minutes		$105- per session
90832	95 (Telehealth)	Psychotherapy- individual	30 minutes		$70- per session
90847	95 (Telehealth)	Family psychotherapy- conjoint psychotherapy with the client present	55 minutes		$150- per session

Provider Estimates per year *(based on 52 weeks of care)*
Sessions scheduled and attended will be billed at full fee. Sessions not scheduled, will not be billed. Scheduled and missed appointments will only be billed the amount of the cancellation fee: see Practice Policy for details.

For new clients Initial Psychiatric Diagnostic Evaluation fee listed above should be added to this estimate. One time session required by the provider at the beginning of treatment, any additional Evaluation appointments per the request of the client would be an additional evaluation fee of $160.

Formula: (session dollar amount multiplied by frequency)= estimate for one year of service

Estimate using weekly sessions in formula for frequency:
Psychotherapy Individual 55 minutes: $140 x 52 weeks= $7280
Psychotherapy Individual 45 minutes: $105 x 52 weeks= $5460
Psychotherapy Individual 30 min (only for private pay): $70 x 52 weeks = $3640
Family Psychotherapy 55 minutes: $150 x 52 weeks= $7,800

Estimate using bi-weekly sessions(every other week) in formula for frequency:
Psychotherapy Individual 55 minutes: $140 x 26 weeks= $3,640
Psychotherapy Individual 45 minutes: $105 x 26 weeks= $2,730
Psychotherapy Individual 30 min (only for private pay): $70 x 26 weeks = $1,820
Family Psychotherapy 55 minutes: $150 x 26 weeks= $3,900

Estimate using monthly sessions in formula for frequency:
Psychotherapy Individual 55 minutes: $140 x 12 months= $1,680
Psychotherapy Individual 45 minutes: $105 x 12 months= $1,260
Psychotherapy Individual 30 min (only for private pay): $70 x 12 months = $840
Family Psychotherapy 55 minutes: $150 x 12 months= $1,800

Expected cost above is based on frequency and duration of appointments. Provider will give a recommendation of frequency and duration of services based on mental health assessment, presenting problem, severity of symptoms and functioning to demonstrate

medical necessity. However clients can also request frequency and duration based on their own comfort level, availability, affordability and interest.
A recommendation of increase of services may be made based on new presenting problems or triggers causing new symptoms or exacerbation of current symptoms, increased stress in clients life and the request of increase of services. The cost per session remains the same as identified above.
A recommendation for decrease in services may be made based on progress made in stabilization of symptoms, presenting problems, and functioning, improved skills, natural supports or other factors at clients request to reduce frequency and duration of appointments. The cost per session remains the same as identified above.

Provider Information

Katrina Flesvig, MA, LCPC
Pathway Therapy Services, PLLC
2206 North Main Street Suite 230
Wheaton, IL 60187
(Mailing Address Only, Services are provided Telehealth Only)
Phone: 847-986-5921
PathwayTherapyServices@gmail.com
National Provider Identifier (NPI)
NPI individual: 1821247180
NPI organization: 1003572108
Taxpayer Identification Number: (TIN/FEIN): 87-2916418
Licensed Clinical Professional Counseling #: 180.008204

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.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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.

By eSigning this section, I acknowledge I have read and understood the provider estimate(s). *My electronic signature has the full force and effect of a signature affixed by hand to a paper document