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FORM 2: NO SURPRISES ACT / GOOD FAITH ESTIMATE

These first 2 pages are my attempt to provide helpful information as you read through the rest of this document which includes some confusing, repetitive and sometimes intimidating language in the attached form [OMB Control Number: 0938-1401] from the Federal Government.

In January 2022, Federal legislation under Section 2799B-6 of the Public Health Service Act went into effect called The No Surprises Act [NSA] to help patients seek and receive medical treatment and not be surprised by huge, unexpected charges after the fact. This was to address surprise bills that patients would sometimes receive from ambulance services, hospital providers, anesthetists and others that might not be in network as well as other costs that showed up later on hospital and medical facility bills. For those who do not have or choose to not use their insurance, it gives people an estimate of treatment costs. It also provides an opportunity for remedy should a patient receive a surprise bill after the fact. There is a great deal of debate about this act and other issues of implementation/enforcement and professional groups are lobbying to get clarification and modifications made to the act. There was no opportunity for public comment or input to the NSA before it was passed.

The piece of this act that impacts you the most is that the NSA requires providers to give a diagnosis and Good Faith Estimate [GFE] of the cost of treatment before the patient is seen. It also requires that you receive and return this estimate within specific timeframes of scheduling your appointment. It is designed to inform you that you can seek services with someone who is contracted with your insurance company and you are not required to work with me. If the annual estimate is not within $ 400, you have the right to file a complaint against your provider with the Federal Government.

Mental health professionals are trying to respond to the NSA/GFE requirements as best they can. It is easy to say that an ambulance trip will cost a certain price and quote it ahead of time. It is quite another thing to diagnose a patient or estimate the cost of therapy before the patient has even been seen. In my opinion, the No Surprises Act did not take this into consideration.

There are many factors that make compliance with the NSA difficult in mental health care:

1) What people call in with [for instance “I’m stressed” or “I need to deal with my family” or “I want to feel more confident”] is often not diagnosable. In addition, what the therapist is told on the phone will not be the whole situation. There is no way to capture all the important data in an initial phone call and there are frequently other underlying issues that may need to be addressed. I think it makes good sense for someone to wait until they’ve seen and talked with me directly before they tell me their entire story.
2) Sometimes the issue that is creating the problem is not easily identified by the client at the time of the first phone call or e-mail. Often people know that they are hurting, but don’t know why. It can take time to figure that out in the course of therapy.
3) It is not ethical or legal for a therapist to give a diagnosis to a client who has not been seen directly. The American Counseling Association’s Code of Ethics states:
    a. *A.1.c. Counseling Plans: Counselors and their clients work jointly in devising integrated counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients*
    b. *E.5.a. Proper Diagnosis: Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care (e.g., locus of treatment, type of treatment, or recommended follow-up) are carefully selected and appropriately used.*
    c. *E.5.d. Refraining From Diagnosis: Counselors may refrain from making and/or reporting a diagnosis if they believe it would cause harm to the client or others.*
    d. Texas Title 22, Texas Administrative Code, Chapter 681.41 also states*: A licensee must not evaluate any individual's mental, emotional, or behavioral condition unless the licensee has personally interviewed the individual or the licensee discloses in the evaluation the licensee has not personally interviewed the individual.*
    e. That is why you will see the term “deferred” on the GFE is already filled in before I have met with you. I will not comply with the act’s mandate to diagnose without having met you. It is my belief that this could cause serious harm in many situations. If you believe you need a diagnosis prior to treatment, you will need to find another provider.

4) It is impossible to predict how an individual will respond to treatment or how long treatment will last as there are so many variables to consider including [but not limited to]:
    a. See 3a above
    b. motivation
    c. willingness to be in treatment [minors and spouses can be brought against their wishes, court mandated treatment etc.]
    d. intelligence
    e. insight and level of curiosity about themselves
    f. chronic stressors the person has to deal with such as illness, problematic family members etc.
    g. willingness to be open about personal matters – for example, is there an addiction issue or trauma that has not yet been shared with the therapist?
    h. willingness to try new things [ways of thinking, behaviours etc.] and practice outside of session time
    i. impact of medication/medication changes during the course of treatment
    j. addition of new stressors not identified at the outset of treatment
5) Most people are not that interested in making sure that the provider receives these forms within the required timeframe. Instead, most people wait until the day before or day of their appointment to fill out the paperwork. It is their right to do so. The penalty would still be on the provider.

You can probably see that these issues create some incredible difficulties for mental health providers and their patients in using the NSA and trying to come up with a Good Faith Estimate [GFE] of the cost of therapy.

Ultimately, you will do therapeutic work at your own speed and timeframe regardless of external factors. You decide when you are seen, who you see, how long the sessions last and how often you come to therapy. The only exception is when you are a danger to yourself or others and that is when providers step in and enlist the assistance of the police/legal system to keep people safe.

It is possible that other services could be provided that are not listed on this form. You have a right to seek 'remedy' or file a complaint if you feel you have been charged in some manner not identified in this paperwork.

As part of my "Good Faith Effort" [pun intended] to meet these conflicting requirements, you will find a chart of fees and charges attached. The chart shows a Good Faith Estimate of the maximum cost a client could incur in the course of a year. Please note that most people come in once a week, once every two weeks or monthly for either a 50 minute or 90-minute session. If you need more than that, you probably need a higher level of care such as an Intensive Outpatient Program or Inpatient mental health care.

I have also combined the OMB form with the additional pages of instruction to try to reduce the amount you have to read.

Please note that mental health providers have been required for decades to provide a document called a Professional Disclosure Statement/Informed Consent so that there were/are no surprises to the client. No other health professional has ever had to do that. Unfortunately, the government has required that you have to read that multiple page document as well and initial/sign it before treatment proceeds. It is discussed again during the first session to make sure you have no questions. The GFE is largely a duplication of effort required by law for mental health professionals. The GFE must be updated annually or if there is a change in the treatment strategy. Ironically, the NSA also includes a statement that this act is in compliance with the Paperwork Reduction Act!

You will also sign a form giving me permission to use your credit card for session fees, no showed appointments, late cancellations, report preparations, emergency calls, case consultations, sessions that run over time and court/legal time etc. My intent has always been that you never be surprised by a charge or fee.

You are now, and always have been, free to discontinue treatment at any time which will end any fees unless the therapist is called into court or is asked for reports/consultations on your behalf regarding your treatment after you terminate treatment.

You can get more information about the NSA and GFE at www.cms.gov/nosurprises

Sincerely,

Sharon L. Ward, MS, LPC, NCC

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd 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 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. Take a picture and/or keep a copy of this form for your records.

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either: • A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or • A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities. These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary's specifications regarding the form and manner of the notice and consent documents. These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The individual must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual. If an individual makes an appointment for the relevant items or services at least 72 hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

[To facilitate compliance with these requirements, this form is always available for download on my website, sharonwardcounseling.com or you may contact me]

If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, Baltimore, Maryland 21244-1850.

You're 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 doesn't 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're 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're 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 the next page for your cost estimate.

Questions about your rights? Contact: 1-800-985-3059.

You can get more information about the NSA and GFE at www.cms.gov/nosurprises

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care. With my signature, I'm agreeing to get mental health counseling and related services from Sharon L. Ward, MS, LPC, NCC. With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that I'm 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 on [the date you scheduled your appointment/received this form] _____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 getting 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.

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. You will find the good faith estimated cost for the items and services that would be furnished by Sharon L. Ward, MS, LPC, NCC plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. You will need to assume no coverage would be provided for any of the items and services by your insurance company

Your Rights and Protections Against Surprise Medical Bills:

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. You can also get the items or services described in this notice from providers who are in-network with your health plan:

More information about your rights and protections. When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible. 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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service. You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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. 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 can 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 types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have these protections: You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly. • Generally, your health plan must: Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit. If you think you've been wrongly billed, contact

1-800-985-3059. Visit www.cms.gov/nosurprises/consumers 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 Sharon L. Ward, MS, LPC, NCC.

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 _____ [same date as above] 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, 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.

_____ or _____

Patient's signature Guardian/authorized representative's signature

_____ _____

Print name of patient 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.

SHARON L. WARD, MS, LPC, NCC

Tax ID: 75-2963054 NPI: 1235298118

GOOD FAITH ESTIMATE FOR HEATLH CARE ITEMS AND SERVICES

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. 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. 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.

First Name Middle Name Last Name

Date of Birth Email Address

Street or PO Box _____ Apartment or Suite _____

City State Zip-code

Contact Preference [ ] Mail [ ] email [ ] in-person

Initial Patient Diagnosis *deferred* Diagnosis Code *deferred*

Subsequent Diagnoses

DX _____ Code _____

DX _____ Code _____

DX _____ Code _____

Frequently used Service Codes and associated costs for individual therapy

CMS/CPT Code	Description	Duration	Fee	Maximum Qty per year	Yearly Total
90791	Initial Assessment	90 minutes	$ 180	1	$ 180
90837 Monthly	53-60 minute session – individual	53-60 minutes	$140	12 sessions [1 session every month for 12 months]	$ 1680
90837 bi-weekly	53-60 minute session – individual	53-60 minutes	$140	26 sessions [1 session every other week for 52 weeks]	$ 3640
90837 weekly	53-60 minute session – individual	53-60 minutes	$140	52 sessions [1 session per week for 52 weeks]	$ 7280
90837 2 times per week	53-60 minute session - individual	53-60 minutes	$ 140	104 sessions [2 sessions per week for 52 weeks]	$ 14,560
90832	30 minute session - indiv. Not an option for regular visits. This is not enough time to be therapeutic in most cases.	30 minutes	$ 100	104 sessions [2 sessions per week for 52 weeks]	$ 10,400
90837+90832	90 minute session – individual [used for EMDR and where client has requested a longer session]	90 minutes	$ 180	104 sessions [2 sessions per week for 52 weeks]	$ 18,720
Modifier codes, descriptions and cost					
+99354	Session extends over 90837 [60 minutes – individual or family]	Per minute up to 134 minutes [74 minutes]	$ 3.00 per minute	2 sessions per year [If you need more than this, you will I probably be referred to a higher level of mental health care]	$ 444
+99355	Session extends over 99354 [134 minutes – individual or family]	Per minute up to 164 minutes [30 minutes]	$ 3.00 per minute	2 sessions per year [If you need more than this, you will probably be referred to a higher level of mental health care]	$ 180

90839	Therapy for crisis	Max 60 minutes	$ 3.00 per minute	2 sessions per year [If you need more than this, you will probably be referred to a higher level of mental health care]	$ 360
+90840	Therapy for crisis add-on	Max 30 minutes	$ 3.00 per minute	2 sessions per year [If you need more than this, you will probably be referred to a higher level of mental health care]	$ 180
+99050	Services outside of business hours	Max 60 minutes	$ 3.00 per minute	2 per year If you need more than this, you will probably be referred to a higher level of mental health care]	$ 360
Frequently used Service Codes and associated costs for couples and family therapy					
90846	Psychotherapy with family, patient not present	53-60 minutes	$ 140	6 sessions per year [If you need more than this, you will probably be referred to a family therapist]	$ 840
90847	Family therapy	50-60 minutes	$ 140	6 sessions per year [If you need more than this, you will be referred to a family therapist]	$ 840
90847+90832	90-minute therapy session [pre-marital or marital therapy]	90 minutes	$ 180	104 [2 sessions per week for 52 weeks]	$ 18,720
Other fees you may incur					
-GT modifier	Telehealth or phone session	n/a	No additional cost	Added to the above codes where applicable	
Court appearances			Flat rate of $ 1000 per day		
Report preparation, copying files			$ 140 per hour		
Psychiatrist/physician evaluation/medication mgmt, intensive outpatient/inpatient care, crisis evaluation	These services are not provided by Sharon L. Ward, MS, LPC, NCC. You will be referred for these services.	Unknown	Unknown	unknown	
Consultation with other providers after 10 minutes			$ 3.00 per minute		
Phone consult with patient or family over 10 minutes			$ 3.00 per minute		
No Showed Appointment 50 minutes			$ 140	3 sessions. After 3 sessions you will be referred to another provider	$ 420
No Showed Appointment 90 minutes			$ 180	3 sessions. After 3 sessions you will be referred to another provider	$ 540
Less than 24 hour cancellation 50 minute session			$ 140	3 sessions. After 3 sessions you will be referred to another provider	$ 420
Less than 24 hour cancellation 90 minute session			$ 180	3 sessions. After 3 sessions you will be referred to another provider	$ 540

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

This form expires on December 31 of the year it was signed.