

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENT
(WITH GOOD FAITH ESTIMATE)
(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protection from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

You are not 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.

Ask your counselor if you need help knowing if these protections apply to you

Patient name:

Out-of-network provider(s) or facility name: Sage Counseling and Wellness

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. Please see the breakdown of possible fees on page four.

- ▶ **Review your detailed estimate.** See page three for a cost estimate for each item or service.
- ▶ **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.
- ▶ **Questions about this notice and estimate?** Call your counselor: 404-490-1566
- ▶ **Questions about your rights?** Contact: The Georgia Secretary of State's office: 404-656-2881

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/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 I might 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): Sage Counseling and Wellness

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 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 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.

Patient's signature/ Parent/Guardian/Authorized Representative's signature

Date and time of signature

Print name of the patient

Print name of guardian/authorized representative

Sage Counseling and Wellness
rachel@sagecounselingtherapyandwellness.com
404-490-1566 www.SageCounselingTherapyAndWellness.com

FEDERAL TAX ID: 83-3914059 GROUP NPI #: 1679292734

Patient name: _____ **Date of Birth:** _____

_____ **Diagnosis: Z65.9** Problem related to unspecified psychosocial
circumstances

Out-of-network counselor and facility name: Sage Counseling and Wellness & Rachel Dorneanu MS LPC NCC

The fee schedule will be given to you by your counselor prior to your first appointment. The amount is only an estimate; it isn't an offer or contract for services. The estimate will show 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 the estimate. Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

The Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

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.

90791 Initial Diagnostic Evaluation (80 minutes) \$240

90837 Psychotherapy ≥ 50 minutes (This fee is my hourly rate & used for all prorated calculations as indicated) \$150

90846 Family Psychotherapy without Patient Present, 50 minutes \$160

90847 Family Psychotherapy with Patient Present, 50 minutes \$160

98966-98968 Telephone Assessment & Management: Prorated based on the amount of time spent at an hourly rate

98970-98972 Online Digital Evaluation & Mgt (Responding to Email & Text Messages) Prorated based on the amount of time spent at an hourly rate

Cancellation Fee: Your Therapist Requires a 24-Hour Cancellation Fee, You are Responsible for the Fee of the Appointment Missed

Production of Records: One Time Fee For Record Production \$160

For File Summary: Prorated based on the hourly rate

Legal Fees: Consulting with lawyers, preparing for court, driving to court, time spent in court:
160/hour

Total Estimate: This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns. ***Please note that the Place of Service (in-office vs. telemental health) is not delineated above since the charges are identical.