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SUPPORT | GROW | SUCCEED

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Dear Client,

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

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

Please review the information on the following pages before your first appointment. If you have any questions, please don't hesitate to ask.

Thank you very much,

Brad Hieger, Ph.D.

Licensed Psychologist

Clinical Director

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

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 healthcare 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.

For more information please see Georgia House Bill 888, intended to protect consumers who have received emergency healthcare 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 may be out-of-network. In these cases, the most that 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't bill** you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't 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.

If you believe you've been wrongly billed, you may contact the Office of Georgia Secretary of State at (470) 240-5060.

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.

Good Faith Estimate for Health Care Items and Services*

Patient Information			
First Name	**M.I.**	**Last Name**	**Date of Birth**
Patient Mailing Address, Phone Number, and Email Address			
Street or P.O. Box			**Apartment/Suite**
City	**State**		**Zip Code**
Phone	**Email Address**		
Primary Service Requested/Scheduled			
(Choose one): Counseling			
If Scheduled, list the date(s) the Primary Service or Item will be provided:			
Preliminary Diagnosis:			Z65.9
Date of Good Faith Estimate:			
Estimated Total Cost for Weekly Services for a Year**	**$150 x 52 = $7,800 Mid-Level $170 x 52 = $8,840 Psychologist**		

*** The estimated costs are valid for <u>12 months</u> from the date of the Good Faith Estimate.**

**** Total subject to change depending on therapy needs.**

***** Negotiated fees are subject to revision based on frequency of sessions, i.e. once a client returns to bi-weekly or once a month services, the fee will return to the full rate.**

Provider Name		Provider's National Provider Identifier (NPI)
Street Address		
City	**State**	**ZIP Code**
	GA	
Office Name		**Taxpayer Identification Number (TIN)**
Focus Forward Counseling and Consulting, Inc.		26-4361897

** This is an estimate and not a guarantee of costs 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. Even when eligibility and/or benefits are verified by Focus Forward, we cannot guarantee their accuracy. It is also your responsibility to know if your insurance has rules and regulations for referrals from primary care physicians, pre-certification, limits on outpatient charges, or specific physicians and/or clinics to use that can affect costs. You agree to accept responsibility for co-payments, deductibles, and other services that are provided to you which are not specifically covered by your insurance plan or denied due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan.

Fee Schedule

***Number of Sessions Will Be Determined as We Progress*

Date of Service (If Known)	Service code (CPT Code)	Description	Master's Level (L.P.C/ L.C.S.W./ L.M.F.T.) Fee for Service**	Doctorate Level (Ph.D) Fee for Service**
	90791	Initial Diagnostic Evaluation, 16 or more minutes	$150	$170
	90832	Psychotherapy, 16-37 minutes	$85	$90
	90834	Psychotherapy, 38-52 minutes	$115	$130
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$150	$170
	90839	Psychotherapy for a Crisis (30-74 minutes)	$150	$170

	+90840	**Psychotherapy for a Crisis** **(add on code for each additional 30 mins)**	**$80**	**$90**
	90846	**Family Psychotherapy without Patient Present, 26 or more minutes**	**$115**	**$130**
	90847	**Family Psychotherapy, 26 or more minutes**	**$170**	**$190**
	96130-96133, 96136-96139	**Psychological and Neuropsychological Testing**	**$200 per hour**	**TBD***
	98966-98968	**Telephone Assessment & Management**	**Prorated based on the amount of time spent at hourly rate of $150**	**Prorated based on the amount of time spent at hourly rate $170**
	No Show/ Late Cancel	**Your Therapist Requires a *minimum* two business days' notice**	**$95**	**$95**

	Production of Records	**Copy and/or forward records to other persons, professionals, or offices**	**$50**	**$50**
	Legal Fees	**Preparation and travel time**	**$250/hour**	**$300/hour**
	Legal Fees	**Deposition and Live Testimony**	**$305/hour**	**$380/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 Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.				

***Fees for psychological testing services are listed on page 4 of this document and subject to revision pending your initial consultation with your psychologist along with any associated determination of testing needs.**

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 877-696-6775.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 877-696-6775.

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.