SURPRISE BILLING COLLECTION NOTICE & CONSENT WITH GOOD FAITH ESTIMATE

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 healthcare 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.

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured OR who is insured but does not plan to use their insurance benefits to pay for health care items and/or services.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for therapy services provided to you. While it is not possible for a therapist to know, in advance, how many therapy sessions may be necessary or appropriate for a given person or family upon the initiation of therapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of therapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

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 amounts you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

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, 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 pages for your cost estimate.

Sample Good Faith Estimate

ESTIMATE OF WHAT YOU COULD PAY IF YOU GIVE UP YOUR PROTECTIONS

Out-of-network provider(s) or facility name:

- Independent Provider: _____
- Telehealth

The total cost estimate of what you could be asked to pay is found in the DETAILED ESTIMATE that follows.

ADDITIONAL IMPORTANT INFORMATION

► **Review your detailed estimate.** See the next pages for a cost estimate for each item or service you could get.

► **Call your health plan**. Your plan may have better information about how much you'll 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 Kristin Coen at 704-444-0087. Privacy officer is Dr. Jan Newman.

► **Questions about your rights?** Contact 1-800-985-3059

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 the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options

You can get the items or services described in this notice from a different provider by considering in-network providers covered by your plan:

- Aetna: https://www.aetna.com/individuals-families/find-a-doctor.html
- Anthem: https://www.anthem.com/find-care/
- BCBS: https://www.bcbs.com/find-a-doctor
- Cigna: https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001
- Tricare: https://www.tricare.mil/FindDoctor
- United Healthcare: https://www.uhc.com/find-a-doctor

If you have other insurance, please search their page for providers in your area that accept your insurance.

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

SIGNATURE AND AGREEMENT

By signing this document electronically, 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 the items or services noted above and agreed upon mutually with my provider: **Dr. Will Hasek**

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 signed 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's in your health plan's network.

Take a picture and/or keep a copy of this form.
It contains important information about your rights.

MORE DETAILS ABOUT YOUR TOTAL COST ESTIMATE

Independent Provider Name: _____

[SAMPLE ONLY]

This is an estimate of what you could pay if you give up your protection under the Act.

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.

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ASSUMPTIONS OF THIS ESTIMATE

Although it is not possible for a therapist to know, in advance, how many therapy sessions may be necessary or appropriate at the beginning of therapy, this form provides some information on what you could expect.

Number of sessions. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including: your schedule, attendance, treatment adherence (e.g., completion of assignments and practice outside of session), personal finances; therapist availability, on-going life challenges,the nature of your specific referral concerns and how you address them

Cost. In general, you will find that the cost of therapy varies between professionals based on a few different factors including: session length, type of service (assessments vs. therapy vs. emergency support), therapist training and experience, licensure status, type of degree (masters vs PsyD or PhD), certifications and specialized or advanced training, and more. We also have a 48 hour cancellation policy. You would be charged the full session fee for cancellations outside of that window and for appointments for which you are more than 20 minutes late. These rates would also be higher if your therapist changes his or her rates.

Below you will find an example of an estimate for a therapist charging our current maximum rates.

IMPORTANT: Your actual costs may be higher than this estimate.

Please note that if Provider provides you with a discounted rate, that will be noted, and you may have difficulty obtaining ANY reimbursement from your insurer for out-of-network services.

Provider Current Rates

Provider	Intake Session	Standard Session	Assessment
Dr. Will Hasek	**$275**	**$250**	**$3,000**

TOTAL COST ESTIMATE

In general, to begin with, we recommend that new clients begin with weekly sessions for the first 8 - 12 weeks. This allows us the necessary time to assess and understand your presenting concerns, build our rapport, and begin any immediate skill-building you may need. After this initial period, most clients either continue at this frequency or reduce to biweekly depending on your progress and needs at that time. You will work collaboratively with your therapist to ensure you are only attending sessions as needed and as deemed effective/helpful by you.

Most exposure-based therapies take longer, and the standard length of treatment is 12 - 24 weeks.

GENERAL PSYCHOLOGICAL TREATMENT | 50-minute sessions

Total Estimated Cost for 8 weeks of therapy + intake : $2,275

1 Diagnostic Assessment or Standard Intake ($275) and 8 weekly sessions of Standard Individual Psychotherapy (50 minute sessions, 8 sessions at $250 = $2,000)

Total Estimated Cost for 12 weeks of therapy + intake: $3,275

1 Diagnostic Assessment or Standard Intake ($275) and 12 weekly sessions of Standard Individual Psychotherapy (50 minute sessions, 12 sessions at $255 = $3,000)

Due to the fact that your treatment planning is ongoing and dependent on your individual progress and needs, we would like to provide you with other options for treatment including 24 weeks (roughly 6 months) of therapy + 48 weeks (roughly 12 months)

Total Estimated Cost for 24 weeks of therapy + intake: $6,275

1 Diagnostic Assessment or Standard Intake ($275) and 24 weekly sessions of Standard Individual Psychotherapy (50-minute sessions, 24 sessions at $265 = $6,000)

Total Estimated Cost for 48 weeks of therapy + intake: $12,275

1 Diagnostic Assessment or Standard Intake ($275) and 48 weekly sessions of Standard Individual Psychotherapy (50-minute sessions, 48 sessions at $265 = $12,000)

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’s in your health plan’s network.

BY GIVING MY ELECTRONIC SIGNATURE. I AGREE THAT THIS DOCUMENT HAS BEEN READ, AGREED TO, AND ACKNOWLEDGED BY THE PATIENT AND/OR LEGAL GUARDIAN (IF PATIENT IS A MINOR OR DEPENDANT). IF JOINT PARENTING WITH A MARRIED COUPLE IS THE SERVICE, BOTH PARENTS ARE AGREEING TO THIS DOCUMENT AS THE “PATIENT.” I AGREE TO COMPLY WITH THE TERMS CONTAINED IN THIS AGREEMENT AND AFFIRM THAT MY ELECTRONIC SIGNATURE, AND ALL FUTURE ELECTRONIC SIGNATURES, WERE SIGNED BY MYSELF WITH FULL KNOWLEDGE AND CONSENT AND AM LEGALLY BOUND TO THESE TERMS AND CONDITIONS.