Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

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 nonemergency 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. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients. In particular, providers and facilities must fill in the blanks in the "Estimate of what you may pay" section and the "More details about your estimate" section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements.

The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual. The individual must be provided with a copy of the signed consent documented 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.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the standard notice and consent documents given to patients.

Paperwork Reduction Act Statement

Good Faith Estimate for Health Care Items and Services
Nashville Mental Health Partners
(615) 422 5056 Phone MiriamMRose@ProtonMail.com

This estimate covers both in-person and telehealth appointments.

Date of this Estimate:
This Good Faith Estimate (GFE) is valid for 12 consecutive calendar months from date signed.

Client Information:
Client Name:
Client DOB:
Client Contact Information: _____
Street Address City State Zip

SURPRISE BILLING PROTECTION FORM
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 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 are 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.

Getting care from this provider or facility could cost you more.
If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities; or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.
If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- 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.

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 or sign this form you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate. Estimate of what you could pay.

Patient name:
Out-of-network provider(s) or facility name: **Nashville Mental Health Partners**

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 final pages 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? Miriam Rose, FNP-C**
► **Questions about your rights?** Contact: The Tennessee Department of Commerce and Insurance at 615-741-2218 or 1-800-342-4029 or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

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):

□ **Miriam Rose, FNP-C, Kristian Beach, FNP-BC, Crystal Johnson, FNP-BC, Denise Henderson, PMHNP-BC**

□ **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 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 mounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
• I can send 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 cannot not treat you.

BY SIGNING THE DOCUMENT BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ or _____

Patient's signature Guardian/authorized representative's signature

_____ _____ Print

name of patient Print name of guardian/authorized representative

_____ _____

Date of signature Date of signature

Payment Due at Time of Service

All payments are due at the time of service. I am only able to take credit cards at this time through Square and Cardpointe. Square and Cardpointe requires an active credit card on file for all clients and this card will be charged automatically on the day of service for all applicable fees, including all unpaid fees for services, fees related to declined cards or late cancellations. I am not able to ethically provide a diagnosis to a client before meeting with them. Please note Diagnostic codes provided here are generic and used to satisfy the requirements of the No Surprises Act. Per our verbal discussion and your signature verifying the review of this document, you understand that I do not diagnose. Diagnostic codes in psychotherapy do not change the cost of treatment. For the purposes of this document, your diagnosis is Z71.9 "Counseling, Unspecified".

Provider Estimate

The following is a detailed list of expected charges. Depending on actual services provided, not all of the fees listed below may apply to you. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. The fee for a standard up to 60-minute intake is $250 per session, unless you have a pre-arranged sliding scale fee.

Other fees are as listed:

30 minute Follow Up Appointment - $150, unless you have a pre-arranged sliding scale fee

Late Cancellation fee (less than 24 hours advance notice) - $150

Legal Services - $250 per hour

Crisis Consultation - $50 per 15-minute phone call (There is no charge for the first 15 minutes.)

Copying of Records - $20

Late cancellation fee refers to all cancellations that are made less than 24 hours in advance **unless** the case of emergency (doctor's note provided or COVID-19 related).

Legal services are defined as any participation in legal action whether initiated by the client or by a third party and may include serving as an expert or fact witness in a legal action; being deposed in any civil or criminal matter; meeting with attorneys; transit and waiting time; and any time spent in preparation for testimony.

Crisis consultation refers to all services provided to a client to address a psychological emergency. These services may be rendered in person or via phone and to the client, a healthcare professional, or any other individual as necessary.

Copying of records is defined as any request for the entire medical record.

There is no charge for contact related to scheduling.

Frequency and Duration of Treatment
How long you stay in treatment is entirely up to you. Every client's journey is unique and you are able to stop services at any point. How long and how frequently you engage in therapy is may be influenced by but is not limited to: -Scheduling and life circumstance -Ongoing Life Challenges -The Nature of your Specific Mental Health Challenges and how you address them. You and your therapist will continually assess your need for therapy and make recommendations. You always have agency to discontinue treatment at your discretion. This GFE is based on the standard of care (1x/month). By signing this document, you are acknowledging that it is possible that you will need more or less frequent therapy, dependent on your individual needs. Over the course of care, there may be additional items or services that are recommended that are not reflected in the initial assessment; some of which may include referrals to other providers. These needs are assessed and agreed upon by both clinicians and clients. It is always your choice to engage in more frequent therapy than 1x/month. If such circumstances occur, a new GFE will be provided. All sliding scale agreements will be honored for multiple sessions in a week.

Details of Most Common Charges for services and items:

90792 – Diagnostic evaluation without medical services (Initial Assessment) - $250
99214 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

What is your payment status?
Personal Cost Estimation
Your current fee per session is $250 for the Initial Assessment session and $150 for a subsequent Self-Pay Session. Assuming you are currently scheduling sessions monthly to every 3 months, and based on a 52-week calendar year (not including holidays, breaks, and other unpredictable fees/services disclosed above) your total estimated cost would be: 1 session x $250 plus 11 (max) sessions x $150 per session = $1,900; regardless if the session is in person, telehealth or a combination of both over the course of the calendar year. This amount 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. Contract your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

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, so actual services and charges could differ from the estimate. Further, if additional services are recommended for your care and are scheduled separately, their costs may not be reflected above. This Good Faith Estimate is not a contract and does not require you to obtain the services or items identified above. 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. For example, as noted in the informed consent information provided to you, services such as report writing, certain types of telephone meetings, requested attendance at some meetings/consultations, preparation of treatment summaries, or other currently unscheduled are costs that could arise during treatment. Also, for clients in crisis or for some other reason, it may be important to meet more

frequently than currently planned. Please contact your provider if there are questions or concerns regarding your bill or for updating this Good Faith Estimate. If you are billed for at least $400 more than this Good Faith Estimate, you have the right to dispute (appeal) 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. It is possible that any issues could be easily addressed with your provider. 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. The initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services you receive. For questions or more information about your right to a Good Faith Estimate or the dispute process, you may call 1-800-985-3059 or visit www.cms.gov/nosurprises or https://www.hhs.gov/about/contact-us/index.html.

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.