In compliance with the No Surprises Act 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 a therapist who cannot accept insurance, is an out-of-network provider, or if a client is uninsured or elects not to use their insurance. It is a federal requirement that we have each client sign this form to begin treatment.

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 at our office, and you can discuss with your therapist to determine when therapy services are no longer desired or needed.

THE NO SURPRISE ACT

(OMB Control Number: 0938-1401) Expiration Date: 05/31/2025

SURPRISE BILLING PROTECTION FORM

Effective Date: 01/01/2022

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 before scheduling care. For example, if a psychiatric hospital scheduled your appointment for you, you may want to review your therapists choices before beginning therapy. You can choose to get care from a provider or facility in your health plan's network, which may or may not 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 either is not able to accept insurance or isn't in your health plan's network and is considered out-of-network. This means the provider doesn't have an agreement with your plan to provide services. **There is a possibility that getting care from this provider could cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You are 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.

If you sign this form, there is a possibility 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.

Before deciding whether to sign this form, you can contact your health plan to see if you could find in-network provider or facility (which may or may not cost less) with availability.

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

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 four for a cost estimate for each item or service. If you have qualified for a rate different than stated below, you will receive an addendum stating the terms and conditions of the qualifying rate.

► **Call your health plan.** Your plan may have better information about how much of these services are reimbursable. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call Norcon Family Counseling at 816-781-2349.

► **Questions about your rights to a Good Faith Estimate?** Visit cms.gov/nosurprises or call **1-800-985-3059.**

► **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 of the date of 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 the Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider or facility, you will have to pay the higher amount.

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.

Understanding your options:

If you are wanting an in-network provider, you can call your insurance company to provide you a list of in-network providers that you can call to see if they have availability to take on new clients.

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.

Good Faith Estimate

Norcon Family Counseling

Federal Tax ID: 43-1691850 Group NPI#: 1669585543

Client name: ______________________________ **Client Date of Birth:**____________

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:

Fully Licensed Therapists:

☐ Seth Haney, LPC
NPI:1104027606

☐ Norman Haney, LCSW
NPI:1225141039

☐ Joni Clausen, LPC
NPI: 1124804059

☐ Michael French, LPC
NPI:1086151666

☐ Joshua Harms, LPC
NPI:1336591890

☐ James Lehnardt, LPC
NPI:1093309726

☐ Penny Engstrom, LCSW
NPI:1972276293

Provisionally Licensed Therapists:

☐ MacKay Crookston, PLPC (thru 05/2024 then anticipated to move to fully licensed therapist)

☐ Laura May, S-MFT

Interns: None at this time

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 or before the signature date explaining that my provider 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.
- I can request to get this notice in paper format if preferred.
- 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 cannot treat you and you will need to contact your insurance for a provider or facility in your health plan's network.

___________________________ or ___________________________________ ____________ am/pm

Client's signature | Guardian/authorized representative's signature | Date & Time

___________________________ ___________________________________ ____________ am/pm

Print name of Client | Print Name of Guardian/authorized representative | Date & Time

GOOD FAITH ESTIMATE TABLE OF SERVICES AND FEES FOR 2024

Disclaimer: The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. It is not an offer or contract for services. 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.

Service code (CPT Code)	Description	Provider's Licensure	Fee for Service (Number of Sessions Will Be Determined as We Progress)
90791 90837 90847	Initial Diagnostic Evaluation Psychotherapy ≥ 53 minutes Family Psychotherapy 50 minutes	Fully Licensed Therapists LCSW, LPC, LMFT	$140* per session
90791 90837 90847	Initial Diagnostic Evaluation Psychotherapy ≥ 53 minutes Family Psychotherapy 50 minutes	Provisionally Licensed Therapists LMSW, PLPC, PLMFT	$75-$115* per session *Sliding Scale Based on Household Income and Household Size*
90791 90837 90847	Initial Diagnostic Evaluation Psychotherapy ≥ 53 minutes Family Psychotherapy 50 minutes	Finishing Up Master's Degree Intern, Counselor in Training	$50* per session until therapist finishes internship
No Show Fee	Appointments missed without prior cancellation	All providers	$75 *or full session cost, whichever is lower*
Late Cancelation Fee	Appointments canceled within 24-Hours of a scheduled appointment	All providers	$50 *or full session cost, whichever is lower*
Production of Records	Request for Chart Records	All providers	$25 service fee plus $.66 per page
Report or Form Fee	Requests for Reports Requests for Forms to be Completed	All providers	$50
Court Appearances	The total time is calculated as the total time the therapist is away from the office (this includes travel time) even if the court is canceled or the therapist is not called to testify.	All providers	$800 initial non-refundable minimum fee. If the therapist is out of the office longer than two hours, a $250 per hour fee will be charged for the additional time.
Out-of-Office Meetings	Depositions or any other out of office meetings.	All providers	$250 per hour
*All sessions are billed based on therapist's licensure. As therapists progress in their licensure status, rates for sessions will change accordingly.			
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. Where scheduling allows, most people start off with weekly sessions. Although each client is different, it is typical to expect 3-6 months of therapy or longer based on the client's specific situation.			