

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 is an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance. It is a federal requirement that we have each client sign this form to begin/resume 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 SURPRISES ACT  
**STANDARD NOTICE AND CONSENT DOCUMENTS**

(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. 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 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.

**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, 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 find an in-network provider or facility. See the next page for your cost estimate.

**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.
- ▶ **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](https://www.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 TABLE OF SERVICES AND FEES FOR 2023

**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 <i>Sliding Scale Based on Household Income and Household Size</i>
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
No Show Fee	Appointments missed without prior cancellation	All providers	\$75 or full session cost, whichever is lower
Late Cancellation 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 Records	All providers	\$25
Report or Form Fee	Reports or Forms	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.			
<i>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.</i>			