**No Surprise Billing Protection Act 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.**

**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. 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 to 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.

**By signing No Surprises Billing Protection Act, I give up my federal consumer protections and agree to pay more for out-of-network care.**

**With my signature, I agree to get the items or services from Sarah Horvath, LCSW**

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 must pay out-of-network cost-sharing under my health plan.

•I was given a written notice explaining that Sarah Horvath, LCSW is not 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 got the notice either on paper or electronically, consistent with my choice.

•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 might not treat you. You can choose to get care from a provider or facility in your health plan’s network.

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Patient’s signature Guardian/authorized representative’s signature

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Print name of patient Print name of guardian/authorized representative

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Date and time of signature Date and time of signature

**Take a picture and/or keep a copy of this form.**

**It contains important information about your rights and protections.**

**.**

**Your Estimate for therapy services from out of network provider – Sarah Horvath, LCSW**

**Patient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 how much, if any, your plan will pay and how much you may have to pay.**

90791 Initial Evaluation 90 minutes 200.00

90837 Therapy - 60 minutes Patient and or family therapy 150.00

90839 Crises - intervention 60 minutes 150.00

90840 Crises -each additional 30 minutes 75.00

90846 Family therapy without patient 60 minutes 150.00

90847 Family therapy with patient 60 minutes 150.00

The average number of therapy sessions is 12 – 20 sessions, however, this depends on your specific need. Treatment may take 12 – 18 months of individualized care.

Estimated cost for 12 sessions = 1850.00

Estimated cost for 20 sessions = 3050.00

►Review your detailed estimate.

►Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what’s covered under your plan and your provider options. You can also get the items or services described in this notice from providers who are in-network with your health plan.

►Questions about this notice and estimate? Call Sarah Horvath 512-625-4101

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

More information about your rights and protections

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