FAMILY LIFE COUNSELING
AND PSYCHOLOGICAL SERVICES, LLC

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you would like to give up those protections for out-of-network care.

Important: You are not required to sign this form and shouldn't sign it if you did not 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 would like assistance with this document, ask your provider or David, the office manager. Take a picture and/or keep a copy of this form for your records.

You are getting this notice because Family Life Counseling and Psychological Services, LLC is considered out-of-network with your health plan. This means our providers do not have an agreement with your plan to provide services. **Getting care from our providers will likely cost you more.**

If your plan covers the item or service you are 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.

Ask your provider or David, the office manager, if you are not sure these protections apply to you.

If you sign this form, be aware you may pay more because:

- You are 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 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. If there is not 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.

Estimate of what you could pay if you give up your protections

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not 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.

Service Code		
90791	Initial session/assessment	$145.00
90837	Therapy Session/53 minutes to 60 minutes	$145.00
90847	Family Therapy Session	$145.00

The total amount you may be asked to pay: $145 per session

- **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.
- **Questions about this estimate?** Contact the office manager, David, 314-276-7566 during regular business hours.
- **Questions about your rights?** The federal phone number for information and complaints is : 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 or services before you can get them. If your plan requires prior authorization, ask them what information they will need for coverage. Please contact your health plan prior to scheduling services with Family Life Counseling and Psychological Services, LLC. It is likely that you can get the items or services described in this notice from in-network providers in this area.

More information about your rights and protections can be found at:
www.cms.gov/nosurprises/consumers

By signing, I understand that I am giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I acknowledge that I am agreeing to receive services from a provider at Family Life Counseling and Psychological Services, LLC. I understand that all providers at this facility are out-of-network with my plan.

With my signature, I acknowledge that I am consenting of my own free will and I am not being coerced or pressured. I also know that:

- I am 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 written notice that explained my provider or facility is not in my health plan's network, described the estimated cost of 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 do not have to sign this form. If you do not sign, Family Life Counseling and Psychological Services, LLC might not treat you, but you can choose to get care from a provider or facility that is in your health plan's network.

Signature: _____ Date: _____