No Surprises Act Waiver

Hope Counseling Solutions
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License: 39001686A

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 healthcare 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're 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
-When an out-of-network provider treats you at an in-network hospital or ambulatory 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.

Estimate of What You Could Pay

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage.

Diagnosis: Z13.30 Encounter for screening examination for mental health and behavioral disorders, unspecified

Your estimated fees for services are as follows:
CPT Code 90791 (Assessment) $200
CPT Code 90837 (Individual Psychotherapy 53+ minutes) $185
CPT Code 90834 (Individual Psychotherapy 38-52 minutes) $185
CPT Code 90847 (Family/Couples Therapy) $185

For monthly individual sessions, your estimated cost is: $2,620 for the year
For bi-weekly individual sessions, your estimated cost is: $4,640 for the year
For weekly individual sessions, your estimated cost is: $9,080 for the year

Your yearly total will be dependent upon the number of sessions you have in a given year.

An assessment is generally your first session and will only be billed once per treatment episode. Generally, CPT codes 90837 or 90834 are billed for ongoing sessions. If we have agreed on a sliding scale hardship rate, your estimates are different than these amounts and should be calculated based on your rate x the number of sessions per year + 1 assessment per treatment episode.

I only conduct appointments 48 weeks out of the year.

Provider Name: Heather Harris, MS, LMHC
NPI: 1568970523

EIN: 82-2097156
License #: 39001686A

Other services not recognized or reimbursed by insurance companies are available upon request, but never required or unplanned.

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.

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.

If you are billed 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 are billed $400+ more than your estimate. 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.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 877-696-6775. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 877-696-6775.

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.

Questions about this notice and estimate? Call Hope Counseling Solutions 317-961-8366.

Questions about your rights? Go to www.cms.gov/nosurprises or call 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 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
You can also get the items or services described in this notice from these providers who are in-network with your health plan.

More information about your rights and protections
Visit www.cms.gov/nosurprises or call 800-985-3059 for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

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

______________________________ ______________

Signature **Date**