210 Wirt Street SW, Suite 303
Leesburg, VA 20175
703-727-5209

Surprise Billing Protection 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 are receiving 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, 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.

Estimate of what you could pay

Client Name: ____

Out-of-network provider(s) or facility name:
Margaret Lang-Garnhart, LCSW
Evergreen Counseling Center, PLLC
210 Wirt Street SW, Suite 303
Leesburg, VA 20175

The amount below is only an estimate; it isn't an offer or contract for services. While it is not possible for a clinical social worker to know, in advance, how many counseling sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

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.**

Service/Description	Service Code	Expectable Frequency	Estimated Amount to be Billed/Session	Cost for 12 Weeks of Service	Cost for 52 Weeks of Service:
Clinical Assessment	90871	1x	$150.00/Session	$150.00	$150.00
Psychotherapy, Individual – 30 minutes	90832 or 90832-95	As needed	$65.00/Session	$780.00	$3380.00
Psychotherapy, Individual – 50 minutes	90834 or 90834-95	1x/week	$130.00/Session	$1560.00	$6760.00
Psychotherapy, Family/Conjoint (50 minutes)	90847 90847-95	As needed	$130.00/Session	$1560.00	$6760.00
Psychotherapy, Family without client present	90846 90846-95	As needed	$130.00/Session	$1560.00	$6760.00
Client in Crisis Psychotherapy	90839 90840 (beyond 60 minutes) 90839-95, 90840-95	As needed	$130/50 minutes	$1560.00	$6760.00
Missed Appointment Fee		As applies	$60.00	n/a	n/a
Legal Proceedings		As needed/required	$300/hour	n/a	n/a
Consultation and unlisted psychological services		As needed and/or upon client's request	$150/hour	n/a	n/a

Total estimate of what you may owe:	**$150 for initial assessment, followed approximately $130/weekly session for the duration of the clinical treatment period.**

► **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 703-727-5209 to discuss *the documents and estimates to the individual, and answer any questions, as necessary.*
► **Questions about your rights?** Visit www.cms.gov/nosurprises for more information about your rights under federal law.

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.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those

services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Understanding your options
You may also obtain the items or services described in this notice from providers who are in-network with your health plan.

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 am saying that I agree to get the items or services from: Margaret Lang-Garnhart, LCSW at Evergreen Counseling Center, PLLC
- I am giving up some consumer billing protections under federal law and may pay more for out-of network care.
- 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 _______________ 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 received 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. However, if you don't sign, this provider or facility might not treat you. You can choose to obtain care from a provider or facility in your health plan's network.

_______________________________________ Patient's signature
_______________________________________ Print name of patient
____Date

____Guardian/authorized representative's signature
____Print name of guardian/authorized representative
____Date of signature

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