

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE

MEDICAL BILLS

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

For Nevada Residents: **Board of Examiners for Marriage Family Therapists and Clinical Professional Counselors (702) 486-7388**

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

Date of Service	SERVICE CODE (CPT CODE)	DESCRIPTION	FEE FOR SERVICE QUANTITY OF SESSIONS WILL BE DETERMINED AS WE PROGRESS
	90791	Initial Diagnostic Evaluation	\$150
	90832	Psychotherapy, scheduled 16-37 MINUTES	\$105
	90834	Psychotherapy, scheduled 38-53 MINUTES	\$150
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	\$100/per hour
	90839	Psychotherapy for a Crisis (30-74 minutes)	\$150
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	\$105
	90846	Family Psychotherapy without Patient Present, 50 minutes (includes Couple's Therapy)	\$130
	90847	Family Psychotherapy with Patient Present, 50 minutes (includes Couple's Therapy)	\$130
	90853	Group Psychotherapy	\$20
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	CANCELLATION FEE	Your therapist requires 24-hours notice for cancellations	You are Responsible for the Fee of the Appointment Missed
	MEETING FEE	Attending Meetings	Prorated based on the amount of time spent at hourly rate
	PRODUCTION OF RECORDS		\$0.25 per page
	LEGAL FEES		\$250 per hour
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. 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.
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