Surprise Billing Protection Form (Effective 6/1/2022)

This document describes your protections against unexpected medical bills. It also asks if you'd 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 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'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 or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when: • You're 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 health care provider or patient advocate if you're not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

• You're 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 isn't 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.

See the next page for your cost estimate.

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

Patient name:_____

Out-of-network provider(s)or facility name: Resolute Counseling

Total cost estimate of what you may be asked to pay:

►**Review your detailed estimate**. See Page 4 for a cost estimate for each item or service you'll get.

►**Call your health plan**. Your plan may have better information about how much you'll 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?** Contact Michael Linn (owner of Resolute Counseling) at 717-264-0450

►Questions about your rights? Contact 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 and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options

You can get the items or services described in this notice from the following providers who are in- network with your health plan:

More information about your rights and protections

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

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

With my signature, I'm agreeing to get the items or services from Resolute Counseling:

☐

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

• I'm 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 a written notice on that explained my provider or facility isn't in my health plan's network, described the estimated cost of each 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 don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____ or _____

Patient's signature

Guardian/authorized representative's signature

_____

_____

Print name of patient

Print name of guardian/authorized representative

_____

_____

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

More details about your total cost estimate

Patient name: _____

Out-of-network provider(s)or facility name: Resolute Counseling

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 if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
6/3/2022	Resolute Counseling	90791	Intake	$110.00
6/10/2022	Resolute Counseling	90837	53-60 minute	$100.00
6/17/2022	Resolute Counseling	90834	38-52 minute	$75.00
6/24/2022	Resolute Counseling	90837	53-60 minute	$100.00
6/31/2022	Resolute Counseling	90837	53-60 minute	$100.00
Subtotal for Resolute Counseling:	$485.00			
Total estimate of what you may owe:	$485.00			

Resolute Counseling
38 Black Avenue
Chambersburg, PA 17201
Phone – 717-264-0450 ~ Fax – 717-264-0460
www.resolutecounseling.com

- On the following page, please pay attention to our up-to-date fee schedule for allowable services.

Fee Schedule

Effective: 06/01/2022

Out of pocket appointment (Clients not using insurance coverage or for out of network):
CPT Code:
90791 (Intakes – up to 60 minutes): $110.00
90837 (53-60 minute session): $100.00
90834 (38-52 minute session): $75.00
90832 (16-37 minute session): $50.00

No-Show or Late Cancelation:
$50.00 per occurrence

Court and Legal Fees:
$300.00 per hour
This includes but is not limited to: file preparation, travel time, waiting time in court room, testimony, communication with legal counsel(s).

Insurance clients:
Client responsibility will vary based on the client's insurance plan. This includes the variation based on co-pay, insurance, and deductible amount. Clients are responsible for reporting if and when their insurance changes or if and when they lose active coverage. Failure to do so will result in any denied claims being turned into the self-pay rate.

Your Rights and Protections Against Surprise Medical Bills

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 balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

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 protections 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.

https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/2006/0/0176..PDF

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 Pennsylvania Department of Health or The Pennsylvania State Board for Professional Counselors

Visit https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html for more information about your rights under federal law.
https://www.legis.state.pa.us/WU01/LI/LI/US/PDF/2006/0/0176..PDF for PA State Law.

Good Faith Estimate for Health Care Services

Patient

Patient First Name:

Middle Name:

Last Name:

Patient Date of Birth: _____/_____/_____

Patient Mailing Address, Phone Number, Email Address:

Street or PO Box (Apartment # if applicable):

City:

State:

Zip Code:

Phone:

Email Address:

Patient's Contact Preference: [ ] By Mail [ ] By Email

Patient Diagnosis (To be assessed after the first appointment or unless client gives this information before their first appointment)

Primary Diagnosis and Code:

Secondary Diagnosis and Code:

Primary Service Provided:

If scheduled, list the date(s) the Primary Service or Item will be provided:
[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____/_____/_____

Provider Name: Resolute Counseling

Summary of Expected Charges

(See the itemized estimate attached for more detail.)

Total Estimated Cost: $

The following is a detailed list of expected charges in a given month:

Expected Service	# of sessions	Cost (each)	Total Cost
1. 90791		$1100.00	
2. 90837		$100.00	
3. 90834		$75.00	
4. 90832		$50.00	

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

These costs are related on an average of 1 visit per week for 1 months' worth of services.

It is typical for a person to attend counseling for a minimum of 3-4 months to address their mental health diagnosis. The amount of sessions per month is a mutual decision between the therapist and the client based on many factors.

Resolute Counseling Estimate

Provider/Facility Name: Resolute Counseling

Street Address: 38 Black Avenue
City: Chambersburg

State: PA ZIP Code: 17201

Phone: 717-264-0450
Contact Person: Michael Linn
National Provider Identifier: 1760854269

Provider/Facility Type: Outpatient Mental Health

Email – michael@resolutecounseling.com

Taxpayer Identification Number: 47-5346351

***Details of Services for Resolute Counseling (Cost for services is same in-person and for telehealth**

Service/Item	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Intake	38 Black Avenue, Chambersburg	N/A	90791	1	$110.00
53-60 minutes	38 Black Avenue, Chambersburg	N/A	90837	1	$100.00
38-52 minutes	38 Black Avenue, Chambersburg	N/A	90834	1	$75.00

16-37 minutes	38 Black Avenue, Chambersburg	N/A	90832	1	$50.00

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 for 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 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 1-800-985-3059.
For questions or more information about your right to a Good Faith Estimate

or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.