AHPC Good Faith Estimate for Self Pay Clients

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. 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.

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.

The No Surprises Act of 2021 (effective 1/1/2022) introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:
• Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;
• Require providers and facilities to provide good-faith estimates of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good-faith estimates to the individual's plan or issuer;
• Create a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
• Require certain providers and facilities to publicly disclose restrictions on balance billing; and
• Limit billed amounts in situations where a provider's network status changes mid-treatment or
individuals act on inaccurate provider directory information.
* Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act).

Client Information

First name _____ Middle Name_____ Last name_____
Date of Birth ___/____/_____ Street or PO box:_____

City, state, ZIP:_____ Phone number:_____
Email address:_____ Contact preference (mail/email):_____

Client Diagnosis: Z91.4 (personal history of psychological trauma, not elsewhere classified: Coronavirus Pandemic) ***Please be aware that this diagnosis is provisional and for the purposes of this Good Faith Estimate. If you have a current diagnosis with Absolute Happiness Psychotherapy and Consultation, PLLC/Andrea Tolbert, LCSW that diagnosis will continue unless otherwise notified. Diagnostic review is an ongoing clinical process. You will be informed verbally and upon request in writing if the diagnosis is updated in the form of a Treatment Plan or Diagnostic Information form, available for download/printing in the Simple Practice portal. Additionally, a change in diagnosis is highly unlikely to affect this Good Faith Estimate; however, if a significant change in fees occurs for any reason you will be notified with a new Good Faith Estimate.

If you have a diagnosis with AHPC/Andrea Tolbert, LCSW Please write it here:

_____

What is your next date of service for 2022? ___/____/_____

<u>Estimate of Services for 2022: $6,775</u>

Psychotherapy Rates for 2022 are as follows:
$145 Initial/Intake 90min 90791
$120 Individual counseling 50min average (38-52min) 90834
$130 Individual counseling 60min (53+min) 90837
$100 Individual counseling 30min average (16-37min) 90832
$70 30 minutes add on to 90837 for specialty care ie EMDR 99354 *Not typically covered by insurance
$70 30 minutes add on to 90837 90833 *Not typically covered by insurance
$95 45 minutes add on to 90837 90836 *Not typically covered by insurance
$120 60 minutes add on to 90837 90838 *Not typically covered by insurance
$120 EAP 45 minute session 99404
$200 Couples Initial/Intake 90min 90791 *Not typically covered by insurance
$150 Couples counseling 50min 90847 *Not typically covered by insurance

$200 Couples counseling 90min 90847 *Not typically covered by insurance
$150 Family w/ client 90847
$120 Family w/o client 90846
$200 Family counseling 90min 90847 *Not typically covered by insurance
$70 Interactive Complexity add on 90785
$140 Crisis add on 30-74m more 90839
$70 Crisis add on additional 75th minute in 30m increments 90840
$120 Case Management 45-60m; 15m=$30 90887. *Not typically covered by insurance
$60 Group Session 60m 90853

$70 Group Session 90m 90853
$80 Group Session 120m 90853

A typical client engages in psychotherapy on a weekly basis to develop therapeutic alliance and develop treatment goals with the therapist and decreases frequency as goals are obtained. Treatment frequency is dependent upon many factors and is impossible to determine in advance therefore the year of services estimate as required by the federal No Surprises Act of 2022- Good Faith Estimate mandate is based on one initial assessment (90791) and 51 weekly appointments (90837): $6,775

Health Insurance

Do you have health insurance that you Do Not intend to use for your psychotherapy services with Absolute Happiness Psychotherapy and Consultation, PLLC/ Andrea Tolbert, LCSW?
***If you intend to use health insurance benefits please alert Andrea Tolbert, LCSW so that you may receive the Insurance User form-this for is Only for Self Pay and Out of Network clients

Please Circle: Yes No Not sure

Andrea Tolbert, LCSW, LICSW, MBA, MHRT-CSP is a Licensed Clinical (Independent) Social Worker in Maine LC17051, Vermont 089.0134276, and Florida Telehealth Registry TPSW1376.
405 Western Avenue South Portland, ME 04106
207-317-2711 phone 844-368-9004 fax

More information regarding Andrea or Absolute Happiness Psychotherapy and Consultation, PLLC can be found on the Absolute Happiness website or Psychology Today:
AbsoluteHappinessPsychotherapy.com
https://www.psychologytoday.com/profile/374438

If you believe Andrea Tolbert, LCSW and/or Absolute Happiness Psychotherapy and Consultation, PLLC has violated the provisions of the No Surprises Act please inform us so that we may have an opportunity to rectify the situation.

You may also report violations to: No Surprises Help Desk at 1-800-985-3059 from 8 a.m. to 8 p.m. EST, 7 days a week, to submit a question or complaint. You may also do so online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing

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.

By signing here I am expressing I have read, understand, and consent to all the policies and information above and attest to the accuracy of the information I have entered above.

Signature_____ **Printed Name**_____

Date_____/_____/_____

PRIVATE PAY AGREEMENT I understand that Andrea Tolbert, LCSW of Absolute Happiness Psychotherapy and Consultation, PLLC is accepting me as a private pay client and I will be responsible for paying for any services that I receive. The provider will not file a claim to Medicaid, Medicare, or any other Insurer/Payer/Health Benefits for the services that are provided to me. I understand that I will be provided Superbills, upon request, to submit to an Out of Network insurer for potential reimbursement in accordance with my policy if it includes Out of Network benefits. I am aware that reimbursement is not guaranteed and Andrea Tolbert, LCSW nor Absolute Happiness Psychotherapy and Consultation, PLLC will hold responsibility for my health insurer's decisions on reimbursement. I acknowledge that I am fully responsible for paying for services at the time they are rendered and at no point will Andrea Tolbert, LCSW of Absolute Happiness Psychotherapy and Consultation, PLLC submit claims on my behalf.

Signature_____ **Printed Name**_____

Date_____/_____/_____

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 billing 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. • This document serves as my 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 electronically, and can request a paper copy • 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.

Signature_____ **Printed Name**_____

Date_____/_____/_____