Barbara Davis MSW, MFA, EXAT, LCSW
20 Mechanic St. Ste 100 PO Box 704 Camden, Maine 04843
207-706-6485 BarbaraDavisLCSW@gmail.com BarbaraDavisLCSW.com
FEDERAL TAX ID: 20-8564981 NPI#: 1871657718

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

The following information is being presented to you due to the new federal law called the "No Surprises Act" which went into effect 1/1/2022. This law requires me to provide you with a "good faith estimate" of the **cost** of your treatment. Estimating the total cost of psychotherapy treatment is very difficult because the course of treatment varies for everyone. The law requires me to make this estimate prior to completing an assessment which further complicates things. In psychotherapy, there are only a handful of CPT codes (billing codes) that can be used and the prices for those codes do not vary. Attached you will find a good faith estimate of the cost of treatment.

Please note that this letter is adapted from a sample written by the CMS to be used by **ALL** medical providers and you may notice the language is quite different than in other documents I share with you. Please direct any questions or concerns you have about this directly to me.

You have a right to receive a "Good Faith Estimate" explaining how much your medical care will cost.
Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
(*Eventually we are likely to need to give this to all patients, including those who are using their insurance*)

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs, like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

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 potentially pay more for out-of-network care.

Important: You are not required to sign this form. You can choose to get care from a provider or facility in your insurance plan's network, which may cost you less. If you'd like assistance with this document, please ask me.

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You're getting this notice because I am not in your health insurance plan's network. This means I don't have an agreement with your insurance plan. **Getting care from me may cost you more than if you were to see an in-network therapist.** Ask your health care provider 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 some legal protections related to health insurance and billing practices
- 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 out-of-pocket limit. Contact your health insurance plan for more information.

Before deciding whether to sign this form, you can contact your health insurance plan to find an in-network provider or facility. If there isn't one, your health insurance plan might work out an agreement with this provider or another one. Please review the cost of treatment on the next page and let me know if you have any questions.

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Estimate of what you could pay

Out-of-network provider name: Barbara Davis, LCSW

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page six..

Call your health insurance plan. Your health insurance plan may have better information about how much of these services are reimbursable.

Questions about this notice and estimate? Call me, Barbara Davis, at 207-706-6485 to answer any questions you may have about this

Questions about your rights? Contact the State Board of Social Worker Licensure
35 State House Station, Augusta, ME 04333-0035, phone: (207) 624-8674 regarding your rights as a client.

Prior authorization or other care management limitations

Except in an emergency, your health insurance plan may require prior authorization (or other limitations) for certain items and services. This means you may need your insurance plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health insurance plan about what information is necessary to get coverage.

More information about your rights and protections

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

***Please return ages 4 and 5, signed,**

to your provider at or before your first appointment*

Take a picture and/or keep a copy of this for your records

It contains important information about billing rights and protections.

Please hold on to pages 1-3. They are for your reference only.*

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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 was given written notice of the provider's billing policies and information about the *No Surprises and Good Faith Estimate Laws* on (write in date) :_____ explaining that this provider is not in my health insurance plan's network and the estimated cost of services for which I am responsible.

If I were using my insurance to pay for services, I may be afforded additional consumer billing protections under federal law that do not currently pertain to out of pocket charges and payments. In addition, if I were to choose to receive services from an in network provider, the charges I need to pay might be lower than what I am paying to see an out of network provider.

I understand that I will get a bill for the agreed upon charges for the services I receive (see page 5) and it is my responsibility to pay such bill in full.

I received this notice either electronically or on paper, consistent with my choice

I fully and completely understand that some or all of the amounts I pay might not be counted towards my health insurance plan's deductible or out of pocket limit. It is my responsibility to check with my insurance company should I plan to submit for reimbursement.

I can end this agreement at any time by notifying the provider in writing before getting services

Please note, you do not need to sign this form however if you don't sign, the provider might not provide services to you. Please speak with the provider directly if you have any questions or concerns.

Print full name _____

Signature and date _____

***Please return ages 4 and 5, signed,**

to your provider at or before your first appointment*

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GOOD FAITH ESTIMATE TABLE OF SERVICES AND FEES

Patient Name: Date:

Service code	Description	Fee for Service	Agreed upon service $ rate-fill in and initial
90791	Initial Diagnostic Evaluation (75-90 minutes)	$200	
90834	Psychotherapy, 38-52 minutes (45 minute session)	$100-125	
90837	Psychotherapy or Expressive Arts Therapy ≥ 53 minutes ("55 minute hour") *(This fee is my hourly rate & used for all prorated calculations as indicated)*	$150	
	Expressive Arts Therapy, extended session (90 minutes)	$175-200	
90853	Group Psychotherapy	$50/group	
98966-98968	Telephone Assessment & Management	*Prorated based on hourly rate	
98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	*Prorated based on hourly rate	
Cancelation Fee	I require a 48 hour notice or a Cancelation Fee may be imposed	½ of your regular fee	

This Good Faith Estimate explains my rate for each service provided. I will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns. Please speak with me directly about your financial situation should you require a reduced fee. Fees are the same for in person and telehealth services, therefore location code is not included in this estimate.

****If you attend therapy weekly for one year, to determine your cost, please multiply the agreed upon service rate above X 48 weeks (the approximate number of weekly sessions we might have based on a 52 week year minus vacations etc). This is your estimated yearly cost*

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