No Surprises Act Notice and Consent- Intern

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(OMB Control Number: 0938-1401)

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. Keep a copy of this form for your records. You're getting this notice because this provider isn't in your health plan's network. This means the provider doesn't have an agreement with your plan. Getting care from this provider could cost you more. If your plan covers the 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 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 below for your cost estimate.

ESTIMATE OF WHAT YOU COULD PAY

Out-of-network provider name: Brittney Rahn

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 below.

► Review your detailed estimate. See below for a cost estimate for each item or service.

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

► Questions about this notice and estimate? Call Jade Wiggins, LPC-MHSP at (615) 431-9153

► Questions about your rights? Contact: Board for Professional Counselors, Marital and Family Therapists, and Clinical Pastoral Therapists at Unit1HRB.Health@tn.gov or (615) 741-5735

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.

By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care. With my signature, I am saying that I agree to get services from Brittney Rahn. 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'm giving up some consumer billing protections under Federal law.

• I may get a bill for the full charges for these services or have to pay out-of-network cost-sharing under my health plan.

• I was given a written notice explaining that my provider 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.

• I got 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 in writing before getting services IMPORTANT: You don't have to sign this form, but if you don't sign, this provider might not treat you. Keep a copy of this form. It contains important information about your rights and protections.

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 how much, if any, your plan will pay and how much you may have to pay.

GOOD FAITH ESTIMATE OF SERVICES AND FEES

- 90791: Initial Diagnostic Evaluation, $50
- 90837: Psychotherapy ≥ 53 minutes, $50
- 90846: Family Psychotherapy without Patient Present, 50 minutes, $50

- 90847: Couples/Family Psychotherapy with Patient Present, 50 minutes, $50

- Cancelation Fee: Your Therapist Requires 24-Hour Notice for missed sessions, $50

- Legal Fees: Preparation for and attendance at any legal proceeding on your behalf, $1,000 flat rate plus $200 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. Please note that Place of Service (in office vs. telehealth) is not delineated above since the charges are identical.