

Standard Notice: “Right to Receive a Good Faith Estimate of Expected Charges” Under the No Surprises Act

The following information is being presented to you due to the new federal law called the “No Surprises Act” which went into effect 1/1/22. This law requires us to provide you with a “good faith estimate of the total cost of your treatment. Estimating the cost of psychotherapy treatment is very difficult because the course of treatment varies for everyone. The law requires us to make this estimate prior to completing an assessment which further complicates things. Attached you will find a good faith estimate of your treatment.

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 & services.

*You have a 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, & hospital fees.

•Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, & 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 & pay more for out-of-network care.

Important: You are not required to sign this form & 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. Take a picture and/or keep a copy of this form for your records.

You’re getting this notice because this psychotherapist isn’t in your health plans’ network. This means the psychotherapist & the facility doesn’t have an agreement with your plan. Getting care from this psychotherapist/facility could cost you more. 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 & services received
- Your health plan might not count any of the amount you pay towards your 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 therapist 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 physician or another one. See below for your cost estimate.

Estimate Of What You Could Pay:

Review of your detailed estimate

- Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan & your provider options.
- Questions about this notice & estimate? Call 512-699-4811 or send an email to this provider at: arttherapyaustin@gmail.com.

By signing, I give up my federal consumer protections & agree to pay more of out-of-network care. With my signature, I am saying that I agree to get the items or services from

Art Therapy Austin
Deanna Miesch, LPC

With my signature, I acknowledge that I am consenting of my own free will & am not being coerced or pressured. I also understand that:

- I am giving up some consumer billing protections under federal law
- I will get a bill for the full charges for these items & services, or have to pay out-of-network.
- I was given a written notice explaining that my provider or facility isn't in my health plan/s network, the estimated cost of services, & 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 & 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.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Good Faith Estimate

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 included any information about what your health plan may cover for out-of-network providers. This means that the final cost of services may be different than this estimate. You & your psychotherapist will determine the frequency of appointments together based on your needs. We are concerned that there will be an element of "sticker shock." Seeing the total cost of a year's work of treatment can be alarming, but there is no guarantee that you will be in treatment for a full year. **Please keep in mind that this estimate does NOT account for any potential out-of-network reimbursement from your insurance carrier.**

Please be aware of the following maximum out-of-pocket scenarios:

1. Therapy typically requires an initial intake appointment (60 min/\$175), plus up to weekly, 60 minute appointments at \$175 each. This could lead to a total cost of \$9,100 over a 12 month period of time.
2. At times, it may be necessary and/or you may choose to have longer therapy sessions of 90 mins (90 min/\$262.50) per week. This could lead to a total cost of \$13,650 over a 12 month period of time.

3. At times, it may be necessary and/or you may choose to have longer therapy sessions of 120 minutes (120 min/\$350) per week. This could lead to a total cost of \$18,200 over a 12 month period of time.

4. At times, it may be necessary and/or you may choose to have more than one session in a given week. If you chose to have biweekly therapy sessions (60 min/\$175), meaning two therapy sessions per week (two 60 min sessions at \$175 each, totaling \$350 weekly), this could lead to a total of \$18,200 over a 12 month period of time.

5. At times, it may be necessary and/or you may choose to have longer therapy sessions of 90 mins on a biweekly basis. If you chose to have biweekly therapy sessions (90 min/\$262.50 each, totaling \$525 weekly), this could lead to a total cost of \$27,300 over a 12 month period of time.

6. At times, it may be necessary and/or you may choose to have longer therapy sessions of 120 mins on a biweekly basis. If you chose to have biweekly therapy sessions (120 min/\$350 each, totaling \$700 weekly), this could lead to a total cost of \$36,400 over a 12 month period of time.

The totals below are EXTREME OVERESTIMATIONS for the vast majority of clients, but we want you to be aware of the possible out-of-pocket maximum costs over 12 months should you require that amount of care:

1. Weekly 60 min therapy: \$9,100
2. Weekly 90 min therapy: \$13,650
3. Weekly 120 min therapy: \$18,200
4. Two times weekly 60 min therapy (2 x weekly): \$18,200
5. Two times weekly 90 min therapy: \$27,300
6. Two times weekly 120 min therapy: \$36,400

First Name

Middle Name

Last Name

Date of Birth

Street or PO Box

Apartment #

City

State

Zip Code

phone (home/cell/work/other)

email address

client's contact preference phone-voicemail or text/mail/email

client primary diagnosis

primary diagnosis code

If scheduled, list the date the Primary Service or item will be provided:

For the purpose of this good faith estimate, it is assumed that sessions are weekly; however, it is between the psychotherapist & client to determine the frequency of appointments.

Date of Good Faith Estimate

Signature

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

The following are our fees for services, your estimate is being based on the fact that you are scheduled to see a Psychotherapist (LPC), should you change providers, please note your fees may increase.

60 min intake \$175
60 min psychotherapy \$175
90 min psychotherapy \$262.50
120 min psychotherapy \$350
15 min phone consult \$43.75
30 min phone consult \$87.50
60 min phone consult \$175

*** This does not account for any potential reimbursement from your insurance carrier.**

Art Therapy Austin

Deanna Miesch, LPC, ATR-BC

1200 E. 11th St., Suite 109

Austin, TX 78702

512-699-4811

NPI: **1619193281**

Disclaimer: This Good Faith Estimate shows the cost of the items & services that are reasonably expected to be for your health care needs for an item or service. The estimate is based on information known at the time of 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. Federal law allows you to dispute (appeal) the bill if this happens. 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 US Department of Health & Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 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 & agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more & get information to start the process go to www.cms.gov/nosurprises
For questions or information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

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.