Surprise Billing Protection Form

** indicates a required field*

Surprise Billing Protection Form

Estimate Of What You Could Pay

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:

* 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.
* I got notice 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 or facility in writing before getting services.
* I was given a written notice on this date explaining that my provider or facility isn't in my health plan's network, the estimated costs of services, and what I may owe if I agree to be treated by this provider or facility.

You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care providers(s) when you receive 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. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

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If your plan covers the item or service you're getting, federal law protects you from higher bills:

* When you get emergency care from out-of-network providers or 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 or patient advocate 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 of facility if there isn't one, your health plan might work out an agreement with this provider or facility or another one.

See the next page for your cost estimate.

You DON'T have to sign this form. But if you don't sign, this provider might not treat you.

*** Client's Name:**

*** Out of Network Provider:**

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

Review Your Detailed Estimate:

See the last page of this document for a cost estimate for each item or service.

Questions About This Notice And Estimate?

Call our billing team at 302-497-4334 or email sbalentinelcsw@gmail.com.

Questions About Your Rights?

Contact: www.cms.gov/nosurprises

Prior Authorizations 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 an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

More Information About Your Rights And Protections:

Visit https://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 the items or services from:**

- [ ] Stacey Balentine, LCSW

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:

* **Please sign here:** _____

I consent to sharing information provided here.

* **Patient or Parent / Guardian Signature** _____

I consent to sharing information provided here.

By checking this you are eSigning this form.

*** Print name of Patient or Parent/Guardian.**

*** Date**

Stacey Balentine, LCSW, LLC

3524 Silverside Road, Suite 33B
Wilmington, DE 19810

Federal Tax ID # 81-1108743
NPI # 1205988615

More Details About Your Estimate:

*** Client's Name:**

*** Date of Birth:**

*** Out of Network Provider:**

IMPORTANT:

The Amount below is only an estimate; it isn't an offer or contract for service. This estimate shows teh 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 costs of services may be different than the 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 TABLE OF SERVICES AND FEES

*** Client's Name:**

*** Date of 1st or next appointment if known:**

Service (CPT) Code/Description of Services/Fees

90791: Initial Diagnostic Evaluation: $150.00
90832: Psychotherapy, 16-37 minutes: $100.00
90834: Psychotherapy, 38-52 minutes: 130.00
90837: Psychotherapy, >53 minutes: 145.00
90846: Family Psychotherapy without patient present: 130.00
90847: Family Psychotherapy with patient present: 130.00
+99354 Psychotherapy extended session (add on code for sessions 30 mins. beyond 53 mins): $140.00
Cancellation fee: No Show or Late Cancel (Less than 24 hours notice) for therapy: $75.00
Production of Records: $30.00
Written Letters: $50.00 and up
Legal Fees: $450.00 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 which will determine the estimate cost for the year, and you can add that number below for reference.

*** Estimate:**

Please note that place of service is not delineated above (in person or telehealth) because the costs are identical.