Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more.

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

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail	[ ] By email	
Patient Diagnosis		
Primary Service or Item Requested/Scheduled: Initial Assessment (Please see attached for a list of itemized services and fees)		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled
Date of Good Faith Estimate: _____/_____/_____ **Summary of Expected Charges** (See the itemized estimate attached for more detail.)
Provider Name — Estimated Total Cost Victoria Hollis, LCSW — $
Total Estimated Cost: $ (See below)

The following is a detailed list of expected charges for psychotherapy, scheduled for 1/20/25 and recurring as needed.. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Victoria Hollis, LCSW Estimate

Provider/Facility Name		Provider/Facility Type
Victoria Hollis, LCSW		Outpatient Psychotherapy
Street Address		
City	State	ZIP Code
Brevard	NC	28712
Contact Person	Phone	Email
Victoria Hollis	706-338-9773	vicki@victoriahollislcsw.com
National Provider Identifier		Taxpayer Identification Number
1215178355		

Details of Services and Items for Victoria Hollis, LCSW

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Psychotherapy Intake			90791	1 (Initial Visit) Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need. This is only an estimate **if** your therapist	$125

Psychotherapy Session 50 mins			90834	were to see you for 12 months	$125

Total Expected Charges from : $
Additional Health Care Provider/Facility Notes: N/A

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time 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. If this happens, federal law allows you to dispute (appeal) the bill.

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 U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar 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 and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 706-338-9773.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

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.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$125
	90832	Psychotherapy, 16-37 minutes	$75
	90834	Psychotherapy, 38-52 minutes	$125
	90837	Psychotherapy 75 minutes	$175
	90846	Family Psychotherapy without Patient Present, 50 minutes	$125
	90847	Family Psychotherapy with Patient Present, 50 minutes	$125
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	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. telemental health) is not delineated above since the charges are identical.

GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you any questions or concerns have been addressed. Thank you!

_____ or _____

Patient's signature — Guardian/authorized representative's signature

_____ _____

Print name of patient — Print name of guardian/authorized representative

_____ _____

Date and time of signature — Date of signature