Surprise Billing Protection Form and Good Faith Estimate for Self-Pay and Out-of-Network Insurances

** indicates a required field*

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Take a picture and/or keep a copy of this form. It contains important information about your rights and protections. You may also request a copy of this form from Solace Mental Health and Wellness LLC at any time.

The purpose of this document is to let you know about your protection 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 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.

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 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 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 amounts 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.

Estimate of what you could pay

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.

► Review your detailed estimate for a cost estimate for each item or service you'll get.

► 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 and your provider options.

► Questions about this notice and estimate? Call Solace Mental Health and Wellness LLC at 410-995-9993 and dial "0"- leave a message and your call will be returned.

► Questions about your rights? Contact CMS Baltimore Headquarters. Toll-Free: 877-267-2323

Prior authorization 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.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan: Call the member services number listed on the patient's insurance card for assistance in locating a local in-network provider.

More information about your rights and protections

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Details of Services Including Service Code, Description, and Associated Fee(s)

New Pediatric Patient (this service will take place once as the initial encounter, and as-needed thereafter):
● Consultation with Family only of Pediatric Patient, 50 minutes (90846) - $150

New Patient Psychiatric Evaluation (one of the following services will take place once, and may include add-on codes as indicated):
● Initial Psychiatric Evaluation, 60-75 minutes (90792) - $250
● Office or other outpatient visit for the evaluation and management of a new patient, 30-44 minutes, or by complexity (99203) - $175
● Office or other outpatient visit for the evaluation and management of a new patient, 45-59 minutes, or by complexity (99204) - $200
● Office or other outpatient visit for the evaluation and management of a new patient, 60-74 minutes, or by complexity (99205) - $250

Follow-up Medication Management Visit (these services are delivered as follow-up appointments based on the patient's treatment needs and may include add-on codes as indicated):
● Psychopharmacology Follow-up, 15-29 minutes (99213) - $125
● Psychopharmacology Follow-up, 30-39 minutes (99214) - $150
● Psychopharmacology Follow-up, 40-54 minutes (99215) - $175

Add-on Codes:
● Add-on psychotherapy, 16-37 minutes (90833) - $100
● Add-on psychotherapy, 38-52 minutes (90836) - $150
● Add-on psychotherapy 53+ minutes (90838) - $200

● Prolonged office or other outpatient evaluation and management service, per 15 minutes (99417) - $75
● Interactive Complexity (90785) - $35
● Brief Behavioral Assessment/mental health screening (96127) - $20

Telephone evaluation and management encounter in between scheduled appointments (these services may apply when a patient and/or responsible party requests provider discussion in between scheduled appointments):
● 5-10 minutes of medical discussion (99441) - $85
● 11-20 minutes of medical discussion (99442) - $100
● 21-30 minutes of medical discussion (99443) - $150

Other Services and Fees (this information serves as notice of additional fees that may incur based on the patient's personal needs and are non-billable to insurance companies):
● No-show / Less than 24 hour notice cancellation / Late to Appointment Fee - $50
● Unplanned Medication Refill Fee Outside of Scheduled Appointments - $25
● Court (Subpoena) Fee - $500/hour
● Paperwork Requests Outside of Scheduled Visits - $30/each side of page
● Medical Records Fee: $.83/page plus preparation fee of $250/hour
● Pharmacogenetic testing: Coverage varies upon insurance plan

Additional Notes and Disclosures

● The Good Faith Estimate provided is based on potential/maximum charges that could be accrued. A patient's treatment plan is an extremely personal experience tailored to the needs of the patient and the presenting concerns. Due to the nature of this unpredictability and Solace Mental Health and Wellnesses LLC's commitment to meeting and catering to the needs of every patient individually, determining the exacting cost of each appointment/encounter is ethically impossible. Depending on your/the patient's treatment needs, services will be provided for a frequency of one of the following and may fluctuate throughout the duration of treatment: Weekly, Bi-weekly, Monthly, As-needed maintenance. As-needed maintenance is reserved for patients who have met treatment goals as defined by both patient and provider/clinician.

● Solace Mental Health and Wellness LLC does not submit billing/claims to out-of-network insurers. Reimbursement efforts are that solely of the patient or responsible party.

● Refer to the Solace Mental Health and Wellness LLC Consent to Policies and Fees for more information, and for information related to the patient or responsible party's submission to the patient's insurance company for potential reimbursement. Contact your provider or Solace Mental Health and Wellness LLC staff with questions or concerns.

You have the 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. ● 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 health care 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. ● Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

*** Print name of patient:**

*** Date of birth of patient:**

*** Print name of guardian/authorized representative (write "N/A" if the patient is the signer):**

*** The out-of-network provider(s) or facility name:**

- ○ Solace Mental Health and Wellness LLC and associated providers

*** Details including Service Code, Description, Maximum Estimated Amount to be billed (select the service(s) which apply to the patient; ask the patient's provider if unsure):**

☐ NEW PEDIATRIC PATIENT APPOINTMENT, AGES 0-16 (first appointment is a parent/guardian consult WITHOUT THE PATIENT PRESENT, for patients 0-16 years old): (Service Code: 90846) Consultation with Family of Pediatric Patient (patient not present), 50 minutes - $150. = $150 (total possible charge)

☐ NEW PATIENT APPOINTMENT FOR AGES 17+ (first appointment for patients aged 17+): (Service Code: 99205) Office or other outpatient visit for the evaluation and management of a new patient, 60-74 minutes, or by complexity - $250. (Service Code: 90838) Add-on psychotherapy 53+ minutes - $200. (Service Code: 90785) Interactive Complexity - $35. 1. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. 2. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. = $525 (total possible charge)

☐ NEW PEDIATRIC PATIENT APPOINTMENT, AGES 0-16 (first appointment WITH THE PATIENT PRESENT, for patients 0-16 years old): (Service Code: 99205) Office or other outpatient visit for the evaluation and management of a new patient, 60-74 minutes, or by complexity - $250. (Service Code: 90838) Add-on psychotherapy 53+ minutes - $200. (Service Code: 90785) Interactive Complexity - $35. 1. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. 2. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. = $525 (total possible charge)

☐ CURRENT PATIENT FOLLOW-UP APPOINTMENT (Pediatrics and Adults): (Service Code: 99215) Psychopharmacology Follow-up, 40-54 minutes, or by complexity - $175. (Service Code: 90838) Add-on psychotherapy 53+ minutes - $200. (Service Code: 90785) Interactive Complexity - $35. 1. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. 2. (Service Code: 96127) Brief Behavioral Assessment/mental health screening - $20. = $450 (total possible charge)

☐ Telephone evaluation and management encounter in between scheduled appointments (these services may apply when a patient and/or responsible party requests provider discussion in between scheduled appointments): (Service Code 99443) 21-30 minutes of medical discussion - $150. = $150 (total possible charge)

*** Date(s) of the intended services or time frame (not to exceed one year from date of signing):**

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

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.

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 items and services, or have to pay out-of-network cost-sharing under my health plan.

● I was given written notice on [refer to electronic record date and time stamp] explaining that my provider or facility 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 or facility.

● 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 or facility in writing before getting services.

With my signature, I am saying that I agree to get the items or services from: Solace Mental Health and Wellness LLC and associated providers.

An eSignature on this form is the equivalent of signing this form by hand.

* **Patient's signature or guardian/authorized representative's signature:** _____

I consent to sharing information provided here.