Jenny Pearson, LICSW 2955 80th Ave SE, Suite 206, Mercer Island WA 98040
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THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION NOTICE

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. Take a picture and/or 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 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 without your knowledge or consent.*

Ask your health care provider if you need help understanding 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/provider 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.

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.

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ESTIMATE of Fees and CONSENT

Patient name:_____

Out-of-network provider: Jenny Pearson, LICSW Federal Tax ID: 91-2133059

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 on the next page.

► **Review your detailed estimate.** See the last page for a cost estimate for each item or service.

► **Call your health plan. Find out how much your plan will pay for OUT OF NETWORK services, what your portion may be and if Prior Authorization is required BEFORE receiving services. Use the CPT Codes listed in the Table of Services below to inquire about coverage.**

► **Questions about this notice and estimate?** Ask Jenny Pearson directly.

► **Questions about your rights?** Contact: Washington State Department of Health, PO Box 47857, Olympia, WA 98504-7857 (800) 633-6838 Email: mailto:HSQAComplaintIntake@doh.wa.gov

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

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 agree to receive services from Jenny Pearson, LICSW.
- 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 on _____ explaining that Jenny Pearson, LICSW is out of network with my health plan and the estimated cost of services of what I may owe.
- 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 receiving or continuing to receive services.

_____ or _____

Patient's signature Guardian/authorized representative's signature

_____ _____

Print name of patient Print name of guardian/authorized representative

Date: _____ Time: _____

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Patient name: _____ **Date of Birth:** _____

☐ **Existing Diagnosis** _____ **or** ☐ **Z65.9** Problem of unspecified psychosocial circumstances

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

2022 GOOD FAITH ESTIMATE — TABLE OF SERVICES AND FEES

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	$250
	90832	Psychotherapy, 20-30 minutes	$140
	90834	Psychotherapy, 30-40 minutes	$160
	90837	Psychotherapy, 40-55 minutes	$200
	90839	Psychotherapy for a Crisis, 60 mins	$200
	+90840	Psychotherapy for a Crisis (add for each additional 30 mins)	$140
	90846	Family Psychotherapy without Patient Present, 55 minutes	$200
	90847	Family Psychotherapy with Patient Present, 55 minutes	$200
	98966-98968	Telephone Assessment & Management	$33/10 min increment
	Missed Session Fee	24-Hour Notice of Cancelation is required	$160
	90889	Reports, letters, copying	$33/10 min increment
	Total Estimate:	This Good Faith Estimate explains the rate for each service provided. We will collaborate together throughout your treatment to determine how many sessions and which services you may need to receive the greatest benefit based on your diagnosis(es) and presenting clinical concerns.	