Journey 4 Hope Counseling Center, LLC
Douglasville, GA 30134
404-577-9177
www.journey4hopecounseling.com

"NO SURPRISE ACT"

In compliance with the No Surprises Act that goes into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services. It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment.

For more information about this act, please visit: <https://www.cms.gov/nosurprises> or <https://www.aha.org/system/files/media/file/2021/01/detailed-summary-of-no-surprises-act-advisory-1-14-21.pdf>

My signature indicates that I have received this notice.

Current Fee List:

- 90791 (Intake): $125
- 90837 (53+ minute session; this rate also serves as my "hourly" rate): $100
- 90834 (37-52 minute session): $80
- 90832 (23-37 minute session): $80
- 90847 (Family Psychotherapy with patient): $100
- 90846 (Family Psychotherapy without patient): $100

Services Not Covered by Insurance:

- Late Cancellation (less than 24 hours notice): $65
- No-Show/No-Call: $65
- Form Completion, letter writing, telephone support: all billed at my prorated "hourly" rate

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My signature indicates that I have received a list of fees for this practice and that I understand whether my provider is “in network” or “out of network” with my insurance company.

_____ _____
Client Name (Please Print) Date

_____
Client’s Signature

If Applicable:

_____ _____
Parent/Legal Guardian Date

_____ _____
Provider Signature Date