



## Surprise Billing Notification Form (Out of Network/Self-Pay Only)

January, 2022

As of January 1<sup>st</sup>, 2022, the Centers for Medicare and Medicaid Services (CMS) instigated a new Federal rule to protect patients from unexpected medical bills and to increase transparency between health care clinicians and patients.

This rule requires all medical and mental health clinicians (including LCSWs) to give a “good faith estimate” (GFE) to patients estimating the cost of services and how long services may last.

I am also required to inform you that I am an **“out-of-network”** provider meaning that I do not submit claims to insurance and do not get paid by insurers.

By signing this form, you acknowledge the following:

- You have made a choice to not use your health insurance and seek a provider who may be in-network with your plan.
- You may or may not pay more for my services than your health insurance plan pays.
- You will pay me the full cost for each service I provide, as we have discussed.

Upon request, I can provide you what is known as a Superbill (receipt), which you can submit to your health insurance company. However, please be aware that your plan might not reimburse you, the payment may be of lesser amount than what you have paid me and/or they might not count any of the amount you pay towards your deductible and out-of-pocket limit.

Should you choose not to sign this form, please contact your health care plan directly for more information on “out-of-network” billing or to assist you in finding in-network provider, what is covered under your plan and other provider options.

Cara Maksimow, LCSW  
10 Fairmount Avenue, Chatham, NJ 07928  
[cfmaksimow@maximize-wellness.com](mailto:cfmaksimow@maximize-wellness.com),  
NPI 1346678885, EIN 464184328

### Good Faith Estimate (GFE)

The “Good Faith Estimate” of what you could pay if you choose to enter treatment is as follows:

I, \_\_\_\_\_ understand that

Cara Maksimow, LCSW, my clinician may provide the following services:

- Individual Psychotherapy

Diagnosis \_\_\_\_\_ CPT Code: 90837 and/or 90834

My hourly rate for the service above is \$ \_\_\_\_\_ per session.

- This represents a “good faith estimate” only of the total annual amount you may be asked to pay and is NOT a contract. It is only an estimate.
- The actual number of visits per year may vary significantly depending on the frequency of visits.
- If there is a dispute about this estimate, you may contact the Department of Health and Human Services within 120 days of the service outlined in this estimate.

Should you have additional questions about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call the “No Surprises” Help Desk at 800-985-3059.

---

With my signature, I understand that I may be giving up some of my federal consumer protections and may have to pay more for self-pay treatment.

With my signature, I am agreeing to get the services from the clinician providing this document.

With my signature, I acknowledge that I am consenting of my own free will, including:

- I received this estimate either on paper, electronically, or by mail, at my choice.
- I fully understand that some or all of the 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 getting services.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_ or \_\_\_\_\_  
Guardian/authorized representative’s signature

\_\_\_\_\_  
Printed patient name

\_\_\_\_\_  
Printed name of guardian/authorized representative

\_\_\_\_\_  
Date and time of signature

\_\_\_\_\_  
Date and Time of Signature

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date and Time of Signature