No Surprises Act Disclosure Form 2022

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act" which requires practitioners to provide a "Good Faith Estimate" about out-of-network care. The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your health care needs for an item or service, a diagnosis, and a reason for therapy. 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 and will be provided a new "Good Faith Estimate" should this occur. If this happens, federal law allows you to dispute (appeal) the bill if you and your therapist have not previously talked about the change and you have not been given an updated good faith estimate.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request, or at the time of scheduling health care items and services to receive a "Good Faith Estimate" of expected charges. Note: The PHSA and GFE does not currently apply to any clients who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement).

Your Rights and Protections Against Surprise Medical Bills:

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a healthcare facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan’s in- network cost-sharing amount (such as copayments and coinsurance). You can’t be billed for these emergency services. This includes services you may get after you’re in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you

and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

· Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

Common Services at Life Revisions Counseling

- 90791-95: Initial therapy intake
- 90837-95: Ongoing individual therapy appointments
- 90834-95: Ongoing individual therapy appointments 45 minutes or shorter
- 90847-95: Ongoing family/Couple's appointments
- 90846-95: Ongoing family/couple's appointments with individual absent.

Common Diagnosis Codes at Life Revisions Counseling, LLC.:

Below are common diagnosis codes at Life Revisions Counseling, LLC: however, the list is not exhaustive. With that said, diagnosis codes can change based on many factors. Please speak to your therapist with any questions or concerns.

-Adjustment Disorder (F43.23), Mental Disorder, Not Otherwise Specified (F99), Depression (F32.9) Anxiety (F41.1), Bipolar (F31.9), PTSD/Post Traumatic Stress Disorder (F43.10).

Life Revisions Counseling recognizes every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/or a new "Good Faith Estimate" will be issued should your frequency or needs change.

Where services will be delivered:
Life Revisions Counseling is an exclusively telehealth practice; as such, all benefits will be quoted as virtual.

By signing this form, I hereby accept that I have read and understood the acknowledgment letter provided above. I declare that the information I have provided above is accurate.