Date of form_____

Surprise Billing Protection Form

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 are not required to sign this form and shouldn't sign it if you do not have a choice of health care providers. For example, if a clinician was assigned to you with no opportunity for you to make requests for a clinician. Before deciding whether to sign this form or request care from this office, you can (and should) contact your health plan to find an in-network provider or facility. If there isn't one, or you choose to see me, your health plan might work out an agreement with this practice.
If you are enrolled in a health plan, you can choose to receive 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. You will receive a copy of this form for your records.

You're getting this notice because this provider or facility is not in your health plan's network.

If you sign this form, you may pay more than you might if this service is provided by your health plan because:
• You are giving up your protections under the law.
• You will owe the full costs billed for services received.
• Your health plan **will not** count any of the amount you pay towards your deductible and out-of-pocket limit, because you opted out of using your insurance and claims will not be submitted to your insurance plan.

Though it is impossible to predict with certainty how many psychotherapy sessions will be necessary or helpful to you, what follows will be an estimate of what you might expect if the services you are requesting occur on a regularly scheduled basis. Your treatment needs and your care recommendations might change, depending on how your needs and symptoms change.

Details about your estimate

Client Name_____

Provider Name Susan Thompson LSCSW LCSW

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 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. You are not required to obtain services listed below, and you are also not required to receive them from me.

Description of Services:

You are requesting evaluation or treatment services, by me on a repeating basis, including additional items you may request such as phone contact or written reports or letters. If there are other items or services that I recommend that are not included in the estimate, below, they must be scheduled and/or requested separately, at which point I will give you another good faith estimate for those services.

Providing an estimate for psychotherapy can be challenging because the length of therapy treatment depends on what we discover and agree upon during the course of our meetings. Some individuals receive psychotherapy for a short period of time, and others remain in treatment for a much longer period of time. Because of this variability, I am offering you this estimate that includes my fees for the services you are requesting. Other services, such as calls or other forms of between-session services, occur on an as-needed basis , so those fees are not included in the total for this good faith estimate, but what I customarily provide are listed below, so that you can understand and plan for costs. If our work together utilizes these additional services on a consistent basis I may reissue this good faith estimate to include those additional costs.

Providing this estimate for evaluation and treatment services are equally challenging, particularly where the scope of the treatment is not known beforehand. This is a common occurrence in diagnostic evaluations where the scope of the evaluation can grow, or where additional data collection becomes necessary. Because of these uncertainties, please note that the following good faith estimate is, at best, a rough approximation of costs and you should anticipate that I will periodically reissue this estimate or issue other good faith estimates as additional information about the scope of services I have been requested to perform becomes clearer.

Important: If there are other services that will require separate scheduling and that are expected to occur before or following the items requested below, separate good faith estimates will be issued to an uninsured or self-pay individual upon scheduling or upon request of the listed items or services, and those estimates (if applicable) are not reflected, below. Additional services I may recommend as part of your care are not included in this good faith estimate; they must be scheduled or requested separately.

Estimate of what you could pay

Client Name_____ DOB_____

Provider Name. Susan Thompson LSCSW LCSW Shrink Inc,

Where services will be provided:

10551 Barkley STE 512

Overland Park, KS 66212

Or telehealth via Zoom

NPI 1881769404

If services are reoccurring, depending on the frequency of sessions and length of this estimate the amount below is a good faith estimate of your cost.

Frequency	Type of Service.	Description	Estimated Fee/hour	Total/estimate time
Evaluation	90791	Initial evaluation		
Weekly	90837	Psychotherapy 1hr		
Bimonthly	90837	Psychotherapy 1hr		
Monthly	90837	Psychotherapy 1hr		

This estimate will be for _____months your estimated cost will be _____

If you have any questions call me at 913-481-4004

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

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially an excess of the expected charges included in the good faith estimate, as specified in 45 CFR §149.620. You can learn more about how to initiate the patient-provider dispute process by visiting https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of healthcare services furnished to an uninsured or self-pay individual.

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 may be giving up some consumer billing protections under federal law.
- I will receive a bill for the full charges for these items and services
- I was given this written notice explaining that my provider 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.
- I received the notice either on paper or electronically.
- I fully and completely understand that some or all amounts I pay **will 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.

  IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ Client's signature

_____ Print name of client

_____ Date and time of signature

_____ Guardian/authorized representative's signature

_____ Print name of guardian/authorized representative

_____ Date and time of signature

_____Expiration date or end of agreement