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THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(Adapted from OMB Control Number: 0938-1401)

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 or not you would like to waive those protections when you choose out-of-network care.

IMPORTANT: You are not required to sign this form and should not sign it if you did not have a choice of health care provider when you received care. You can choose to receive care from a provider or facility in your health plan's network, which may cost you less.

If you would like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You are receiving this notice because this provider is not in your health plan's network. This means the provider or facility does not have an agreement with your plan.

Receiving care from this provider or facility could cost you more than care offered by an in-network provider associated with your health insurance plan.

If your plan covers the item or service you are receiving, federal law protects you from higher bills:

- When you receive emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are waving your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not credit any portion of your payment rendered toward your deductible and out-of-pocket limit. Contact your health plan for more information.

You **should not** sign this form if you **did not** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding to sign this form, you can contact your health plan to find an in-network provider or facility. If there is not one available, your health plan might work out an agreement with this provider or facility or with another provider or facility.

Estimate of what you could pay:

Patient name:_____

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for therapy and how long you would like to remain in therapy, unless you are pursuing mandatory treatment. Therefore, it is impossible to predict the length of time a client will choose to receive services. In this regard, open communication between the client and therapist will be an integral part of the therapeutic process. Please see the breakdown of possible fees on page 4.

- **Please review your detailed estimate.** See page four for a cost estimate for each item or service.
- **Please call your health plan.** Your plan may have better information about how much of these services are reimbursable.

Prior authorization or other care management limitations:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certainitems and services. This means you may need your plan's approval for coverage of an item or service before you receive them. If prior authorization is required, ask your health plan representative about what information is necessary to receive coverage.

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.

By signing, I agree that I might pay more for out-of-network care than care offered by an in-network provider associated with my health insurance plan.

With my signature, I am stating that I agree to receive the items or services from:

Virginia C. Renfroe, MA, LPC
141 E. Mercer St., Suite C
Dripping Springs, TX 78620

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 am giving up some consumer billing protections under Federal law.
- I may receive a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ explaining that my provider or

facility is not 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 or facility.
- I received 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 or facility in writing before receiving services.

IMPORTANT: You **do not** have to sign this form. But without your signature, this provider may not render services.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

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

It contains important information about your rights and protections.

More details about your estimate:

Patient name: _____

Out-of-network provider(s) or facility name: **Virginia C. Renfroe, MA, LPC**

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**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may be required to pay.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
90791	Initial Diagnostic Evaluation 60 minutes	$170
90837	Psychotherapy 53-60 minutes	$160
90839	Psychotherapy for a Crisis 30-74 minutes	Prorated at $160/hour for the amount of time spent.
+90840	Psychotherapy for a Crisis (add on code for each additional 30 minutes)	$80
90846	Family Psychotherapy without Patient Present, 50 minutes	$160
90847	Family Psychotherapy with Patient Present, 50 minutes	$160
98966-98968	Telephone Assessment & Management	Prorated at $160/hour or the amount of time spent beyond 10 minutes.
98970-98972	Online Digital Evaluation & Mgt. (Responding to Email & Text Messages)	Prorated at $160/hour for the amount of time spent beyond 10 minutes.
Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Full Fee of the appointment missed.
	Production of Records	Prorated at $160/hour for the amount of time spent.
	Client legal case proceedings/ Professional consultations	Prorated at $160/hour for the amount of time spent, including travel time. Mileage at 62 ½ cents/mile. Parking fees & mailings billed as incurred.
Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will work together with you on an ongoing basis to determine how many sessions and/or services you may need or wish to receive in order to derive the greatest benefit based on your diagnosis(es) and presenting clinical concerns.	

CPT Codes listed above are subject to change.