Dear Truth Center Client,

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 (attached). 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. Please sign and date before your next appointment and return the signed document before your next appointment. If you have any questions, please don’t hesitate to ask.

Thank you very much,

Lavonda Handy, LMFT
Reanna Noor, LPC
Emily Close, MFT
Exie Adams, MFT

THE NO SURPRISES ACT
STANDARD NOTICE & CONSENT

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 you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get 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 or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get 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 giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** 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 whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

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Total cost estimate of what you may be asked to pay

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

► **Review your detailed estimate.** See page four for a cost estimate for each item or service.

► **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.

► **Questions about this notice and estimate?** Call 267-209-0628 or email info@truthcenterhh.com

► **Questions about your rights?** Contact the Pennsylvania Secretary of State at 717-787-6458.

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get 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 give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from:

☐ Lavonda Handy, LMFT

☐ Exie Adams, LMFT

☐ Eliza Farran, LA-MFT

☐ Annabelle Fuchs, LA-PC

☐ Abigail Smith, LA-MFT

☐ Carly Petroski, LA-MFT

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'm giving up some consumer billing protections under Federal law.
- I may get 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 the signed date below explaining that my provider or facility 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 or facility.
- I got 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 getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you.

_____ 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.

THE NO SURPRISES ACT
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Truth Center for Health and Healing, LLC
FEDERAL TAX ID: 84-2355743
GROUP NPI#: 1487265971

The amount below is only an estimate; it isn't 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**.

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

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Date of Service (if known)	Service Code (CPT Code)	Description	Fee for Service (Number of sessions will be determined as we progress)	Negotiated Fee (If applicable. Number of sessions will be determined as we progress)
	90791	Therapy Intake w. LPC/LMFT	$150-$170	
	90791	Therapy Intake w. MFT	$100-$120	
	90834	Psychotherapy, 38-52 minutes w. LPC/LMFT	$150-$170	
	90834	Psychotherapy, 38-52 minutes w. MFT	$100-$120	
	90837	Psychotherapy ≥ 53 minutes w. LPC/LMFT (code used during majority of sessions)	$150-$170	
	90837	Psychotherapy ≥ 53 minutes w. MFT (code used during majority of	$100	

		sessions)		
	90846	Family/Couples Psychotherapy without Patient Present, 50 minutes w. LPC/LMFT	$180-$200	
	90846	Family/Couples Psychotherapy without Patient Present, 50 minutes w. MFT	$100-$120	
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate	
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate	
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed	

TOTAL ESTIMATE: The Good Faith Estimate explains your Therapist's rate for each service commonly provided at Truth Center for Health and Healing, LLC. Your Therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

Please note that the Place of Service (in office vs. telehealth) is not delineated above since the charges are identical.