Cardinal Counseling, LLC

29 Industrial Park Drive, Suite 6
Hendersonville, TN 37075
(615-970-2445)-Ph; (615-827-0301)-Fax
cardinalcounselingcenter.org

GOOD FAITH ESTIMATE

As of January 1, 2022, under Section 2799B-6 of the federal Public Health Service Act (also referred to as "The No Surprises Act") health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to 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 insurance plan or coverage, which must be provided **both orally and in writing**, upon request **or** at the time of scheduling health care items and services. This law was passed to help protect people from surprise medical bills when receiving out of network or private pay care.

<u>You are receiving this notice because the provider or facility is not in your health plan's network or you are choosing not to file a claim with your health insurance plan</u>. This means the provider or facility does not have an agreement with your plan to cover the cost of counseling services. Therefore, getting care from this provider or facility could cost you more.

As such, you are entitled to receive a good faith estimate of what the charges could be for counseling services provided to you. While it is not possible for a counselor to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of counseling sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

You are not required to sign this form and should not sign it if you did not have a choice of health care provider. You can choose to get care from a provider or facility in your health plan's network, which may cost you less. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility.

A summary of estimated costs are provided below to aid you in making an informed decision to compare it to costs of receiving in- network services.

COST PER SESSION

The per session fee for your provider is set at $125.00 for a 50-60 minute therapy session during the work week (Mon-Fri). The per session fee to meet with your provider on a Saturday is $150.00 for a 50-60 minute therapy session. These rates apply to Individual, family, or couples therapy sessions.

The per session fee to meet for EMDR therapy sessions are $187.50 per 1.5 hour session.

SUMMARY OF ESTIMATED CHARGES FOR M-F SESSIONS

Frequency of Sessions per Month	Monthly Estimated Charge	Yearly Estimated Charge
One 50-60 minute session/Month	125.00	1500.00
Two 50-60 minute sessions/Month	250.00	3000.00
Three 50-60 minute sessions/Month	375.00	4500.00
Four 50-60 minute sessions/Month	500.00	6000.00

SUMMARY OF ESTIMATED CHARGES FOR SATURDAY SESSIONS

Frequency of Sessions per Month	Monthly Estimated Charge	Yearly Estimated Charge
One 50-60 minute session/Month	150.00	1800.00
Two 50-60 minute sessions/Month	300.00	3600.00
Three 50-60 minute sessions/Month	450.00	5400.00
Four 50-60 minute sessions/Month	600.00	7200.00

The *duration of a patient's treatment* and cost of overall treatment is HEAVILY DEPENDENT upon their diagnosis, potential physical health issues, overall prognosis, and ability to partner with your therapist to build rapport, remain committed to the therapeutic process and your willingness to do homework assignments between sessions. (i.e., practicing techniques learned in sessions). Sometimes it takes an individual longer to actuate change if they are resistant to that change and therefore hesitate to take therapeutic suggestions that may improve their rate of progress. Further, you have the right and are encouraged to partner with your therapist in making decisions about your treatment, such as goals, duration, and frequency of sessions.

For these reasons it is impossible to determine the *exact* amount of time you will be in treatment prior to ever meeting with you; however, the above list of treatment durations and estimated charges, based on my set fee outlined above, may be helpful to you as you make the decision to utilize health insurance or not.

If for any reason your treatment duration should exceed 12-months, you will be provided with another Good Faith Estimate if not provided before then.

Other Fees

There is a charge of $62.50 each time you cancel your appointment (**UNLESS** you cancel 24-hours beforehand)

1x Intake Fee based on 1.5 hours	$187.50 for M-F appt/$225 for Sat appt
Phone Consultation Fee	If longer than 15 minutes, there will be a fee ($30 for 16-30 minutes)
Copy of Counseling Records	$20 for first 30 pages, 0.10 for each additional page
Court Testimony Fee	$150.00/hour (this includes court preparation time, wait time, testimony and travel time) If there is a fee for parking, you will be required to reimburse me for that fee **IMPORTANT NOTE:** There will be a $300 deposit due 2 weeks before court appearance. If you should cancel

within 48-hours of the scheduled court appearance, this will be returned to you less any court preparation time that has already occurred. (e.g., If I spent one hour on court preparation time already prior to your cancellation, you will only receive the $150.00 back from your $300.00 deposit). If you should NOT cancel 48-hours before the scheduled court appearance, there will be an additional charge of $125, since at that point I will be unable to recoop the lost income from already showing up in court to testify. (for example, if I have already spent an hour preparing for court {$150} and you were not able or forgot to cancel 48-hours prior to the court appearance {$125}, then you will only receive $25 back from your $300 deposit).

INSURANCE

If you have health insurance and decide to use your coverage to pay for your treatment, the contracted session fee will vary, as each insurance panel contracts individually with mental health providers and there is no way to provide estimates unless I know what your insurance plan is and can verify the benefit amount through your plan. However, I will provide the Good Faith Estimate of charges as soon as possible in accordance with the law.

DISPUTE RESOLUTION

You have the right to initiate a dispute resolution process if the amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate, which by law is defined as $400 or more above the estimate provided to you.

For questions or more information about your right to a Good Faith Estimate or the dispute process, please contact Cardinal Counseling, LLC at 615-970-2445 and ask for Erin Samuels.

The initiation of the dispute resolution process will not adversely affect the quality of the services provided to you.

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

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

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

Estimate of what you could pay if you give up your protections

Patient name:_____
Out-of-network provider(s) or facility name:_____

Total cost estimate of what you may be asked to pay: _____

- ► **Review your detailed estimate**. See Page 7 for a cost estimate for each item or service you will receive.
- ► **Call your health plan**. Your plan may have better information about how much you'll be asked to pay. You can also ask about what's covered under your plan and your provider options.
- ► **Questions about this notice and estimate?** Contact Erin Samuels, Owner of Cardinal Counseling, LLC at 615-970-2445 to receive an explanation of the documents and estimates provided to you, as well as receive any answers to your questions, as necessary.
- ► **Questions about your rights?** Contact TN Board for LPC, LMFT, and LCPT at 665 Mainstream Dr., 2nd Floor, Nashville, TN 37243; (615) 741-5735
  The federal phone number for information and complaints is: 1-800-985-3059

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 the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options
You can get the items or services described in this notice from other providers who are in-network with your health plan.

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

By signing this page, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I am agreeing to get the items or services from (select all that apply):

□ *Erin Samuels, MA, LPC-MHSP* with Cardinal Counseling, LLC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I am agreeing to pay the full charges for these items and services, or will have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed 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 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 or facility in writing before getting services.

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

_____ or _____

Patient's signature | Guardian/authorized representative signature

_____ _____

Print name of patient | Print - guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

Keep a copy of this form. It contains important information about your rights and protections.