Powers Ferry Psychological Associates, LLC
1827 Powers Ferry Rd., Bldg. 22, Atlanta, GA 30339
770-953-4744 ext. 14 Fax: 770-953-4640

The No Surprises Act

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 by utilizing out-of- network care which will likely be more expensive than in- network care. You will be asked to sign a form when you come in for your session if you are seeing a provider outside of your insurance network. You are not required to sign this form if you did not have a choice of health care provider when you received care. You will be receiving this notice because this provider isn't in your health plan's network. This means the provider doesn't have an agreement with your insurance plan. You can choose to get 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, please ask your provider. You should keep a photograph or copy of this form for your records.*

If your plan covers the service you are receiving federal law protects you from receiving higher bills when you get emergency care from an out-of-network provider. Ask your provider to explain if you need help knowing if these protections apply to you.

Upon signing this form, you acknowledge that you understand that you may pay more than you would pay by using your insurance network because:

a) You are no longer being protected by the law involving your insurance company
b) You may owe the full costs billed for services received
c) Your health plan may not count any of the amount you pay towards your deductible and out-of-pocket limit. You can contact your insurance plan for more information on this issue.

You should not sign this form if you did not have a choice of providers when receiving care. For example, if a therapist was assigned to you with no opportunity to make a change. Before deciding whether to sign the form, you can contact your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider, or another one.

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Good Faith Estimate

Client Name_____

Provider Name_____

Provider Tax ID_____ Provider NPI_____

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 fees on the Fee Schedule. This will be available on your therapist's web page bio and/or can be provided for you by your therapist.

Review your detailed estimate. See the Fee Schedule for a cost estimate of each item

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

Questions about this notice and estimate? Contact Yasmin Ali, Office Manager at 770-953-4744 x 30 or you can ask your therapist.

Questions about your rights? Contact the office of the Georgia Secretary of State, www.sos.ga.gov,

404-656-2881

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.

Total Estimate: This Good Faith Estimate explains your therapist's rates for each service provided. 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 in office vs. telemental health services are not separated as charges are the same.

_____
Patient Name

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Psychologist Date