Clear Skies Psychiatry, LLC

Surprise Billing Protection Form + GFE

Expiration Date: 01/01/2024

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

The following information is being presented to you due to the new federal law called the "No Surprises Act" which went into effect 1/1/2022. This law requires us to provide you with a "good faith estimate" of the **total cost** of your treatment. Estimating the total cost of psychiatric and psychotherapy treatment is very difficult because the course of treatment varies for everyone. The law requires us to make this estimate prior to completing an assessment which further complicates things. In psychiatry and psychotherapy, there are only a handful of CPT codes (billing codes) that can be used and the prices for those codes do not vary. Attached you will find a good faith estimate of your treatment.

You have a right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs, like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

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

You're getting this notice because this physician isn't in your health plan's network. This means the physician and the facility doesn't have an agreement with your plan. **Getting care from this physician/facility could cost you more.** Ask your health care provider 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 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 physician or another one. See below for your cost estimate.

Estimate Of What You Could Pay:

- Review your detailed estimate
- Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- Questions about this notice and estimate? Call [720-730-6670 or email drrobinson@clearskiespsychiatry.com

By signing, I give up my federal consumer protections and agree to pay more of out-of-network care. With my signature, I am saying that I agree to get the items or services from:

Clear Skies Psychiatry, LLC
Jody Robinson, MD

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 will get a bill for the full charges for these items and services, or have to pay out-of-network.
- I was given a written notice 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. You can choose to get care from a provider or facility in your health plan's network.**

Patient signature required (Patient or Guardian) **Today's date**

Good Faith Estimate

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 for out-of-network providers. This means that **the final cost of services may be different than this estimate.** You and your psychiatrist will determine the frequency of appointments together based on your needs. This may vary depending on whether you receive services for medication management, therapy, or both. We are concerned that there will be an element of "sticker shock." Seeing the total cost of a year's work of treatment can be alarming, but there is no guarantee that you will be in treatment for a full year. **Please keep in mind that this estimate does NOT account for any potential out-of-network reimbursement from your insurance carrier**.

Please be aware of the following maximum out-of-pocket scenarios:

1. Medication management: typically requires an initial 75-90 min appointment ($575 for minor, $475 adult), plus up to biweekly 30 minute appointments at $200 each. This could lead to a total of $5400.00 over a 12 month period of time.
2. Therapy: typically requires an initial appointment ($575 for minor, $475 for adult), plus up to weekly 50-60 minute appointments pro-rated in 5 minute increments at $400/hour each. This could lead to a total of $19,775.00 over a 12 month period of time.
3. Both therapy and medication management: this would follow the "therapy" model above (#2).

You should also be aware that, since we charge for "other professional services" (described in the new client contract), this may add additional out-of-pocket costs. While it is impossible to predict the exact amount of professional services a patient may need outside of their appointments, you should be aware of the hypothetical estimation of 30 minutes per week, which would add an additional $5/week to your costs, or a 12-month total of $300.00

The totals below are EXTREME OVERESTIMATIONS for the vast majority of patients, but we want you to be aware of the possible out-of-pocket maximum costs over 12 months should you require that amount of care:

1. Medication management: $7500
2. Therapy, or combination therapy with medication management: $20,000.00

It is based on once-weekly therapy for a year, you may attend therapy less frequently than this and your cost would be less, you may attend therapy more frequently than this and your cost would be more.

Patient		
Patient First Name	Middle Name	Last Name
Patient DOB:		
Patient Mailing Address, Phone #, and Email Address		
Street or PO Box		Apartment

City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] Phone [ ] Mail [ ] Email		
Patient Diagnosis *we are unable to diagnose without an assessment		
Primary Service or Item [ ] Requested [X] Scheduled		
Patient Primary Diagnosis **Encounter for screening examination for other mental health and behavioral disorders.**	**Z13.39**	Primary Diagnosis Code
If scheduled, list the date(s) the Primary Service or Item will be provided: **For the purpose of this good faith estimate, it is assumed that sessions are weekly; however, it is between the physician and patient to determine the frequency of appointments.**		
Date of Good Faith Estimate:		

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

The following are fees for services, you estimate is being based on the fact that you are scheduled to see a Psychiatrist (M.D.). In the future, please note your fees may increase, and at that time you will be notified.

	90min Intake (ADULT) 99205	110min Intake MINOR) 99205	50min Session 99214+ 90836	20-30min Session 99212-99214	10 min increments of phone call or document preparing		
PSYCHIATRIST (M.D)	$475	$575	$333	$**200**	$66		

*this does not account for any potential reimbursement from your insurance carrier.

Clear Skies Psychiatry, LLC
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NPI: **1871632877** Tax ID- 83-2883655

Disclaimer: This Good Faith Estimate shows the costs of the items and services that are reasonably expected to be for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Federal law allows you to dispute (appeal) the bill if this happens. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.

You may also start a dispute resolution process with the US Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the Agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a for to start the process go to www.cms.gov/nosurprises
For questions or information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.