


Nurture House
210 2nd Avenue South, Franklin, TN 37064
www.nurturehouse.org, support@nurturehouse.org
615-200-0330

# THE NO SURPRISES ACT
# STANDARD NOTICE AND CONSENT DOCUMENTS

(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.

**Estimate of what you could pay**

**Patient name:_ Out-of-network provider(s) or facility name: Nurture House**

**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 Kristen Peluso, Office Manager of Nurture House, at 615-656-0232 or email her at admin@nurturehouse.org.

►**Questions about your rights?** Contact the Tennessee Health Related Boards at https://www.tn.gov/health/health-program-areas/health-professional-boards.html.

►**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 (select all that apply): ☐ Nurture House

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 at the time my intake was scheduled, 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.

Print name of patient: _____

Print name of guardian/authorized representative: _____

Patient's signature Guardian/authorized representative's 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.**




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**FEDERAL TAX ID: 47-1033796**

**More details about your estimate**

**Patient name: _____**

**Date of Birth: _____**

**Out-of-network provider(s) or facility name: Nurture House**

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. Nurture House does not file insurance for any patients. Some diagnoses (V or Z codes) may not be covered by your insurance if you choose to file out of network.**

# GOOD FAITH ESTIMATE
# TABLE OF SERVICES AND FEES

Client Name: _____

| Service code (CPT Code) / Type of Charge | Description | Fee for Service (Number of Sessions Will Be Determined as We Progress) |
|---|---|---|
| 90791 | Initial Diagnostic Evaluation<br>• If < or > than 45 minutes, additional pro-rated amount per minute added to total | Intern rate-100<br>Post-Master's Clinician-150<br>Licensed Clinician-180<br>Clinical Director-300 |
| 90834 | Psychotherapy, 45 minute session •<br>If < or > than 45 minutes, additional pro-rated amount per minute added to total | Intern rate-100<br>Post-Master's Clinician-150<br>Licensed Clinician-180<br>Clinical Director-300 |
| +90840 | Psychotherapy for a Crisis<br>(add on code for each additional 30 minutes over the initial 45). | Intern rate-67 , Post Master's Clinician-100<br>Licensed Clinician-120<br>Clinical Director-200 |
| 90846 | Family Psychotherapy without Patient Present, 45 minutes<br>• If < or > than 45 minutes, additional pro-rated amount per minute added to total | Intern rate-100<br>Post-Master's Clinician-150<br>Licensed Clinician-180<br>Clinical Director-300 |
| 90847 | Family Psychotherapy with Patient Present, 45 minutes<br>• If < or > than 45 minutes, additional pro-rated amount per minute added to total | Intern rate-100<br>Post-Master's Clinician-150<br>Licensed Clinician-180<br>Clinical Director-300 |
| 90853 | Group Psychotherapy | Group services range from 240-300, depending on the length of group |
| Conjoint Sessions | Sessions where more than one Therapist participates in the session | You pay the above rates for each therapist present. (example: If 2 Post-Masters were present for a 45 min session that would be $300 for the session you attended with both therapists present) |

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| Contact Note | Telephone Assessment & Management, Responding to Email, Text Messages | *Pro-rated per minute if longer than 10 minutes* |
| | Pro-rated amounts for all above Service Codes are as follows | Intern rate per minute -2.22<br>Post-Master's Clinician per minute -3.33<br>Licensed Clinician per minute -4<br>Clinical Director per minute -6.66 |
| Cancellation Fee | Your Therapist Requires a 24-Hour Cancellation Fee | You are Responsible for the Fee of the Missed Appt |
| Production of Records | Digital or Printed | $25.00, payable in advance of receiving records |
| Court Related Fees and Legal Fees for Interns, Post-Masters Clinicians, and Licensed Clinicians | All services related to court involvement, including court testimony, deposition, time spent reviewing records and preparing documents FOR court/legal use, travel time, and communications with parents' legal counsel and/or with Guardian ad Litems, or reading/reviewing legal documents.<br><br>**Interns are NOT permitted to participate in court appearance (testimony or deposition). Interns ARE permitted to speak to legal representatives on behalf of a client.**<br><br>For Post-Masters and Licensed Clinicians, court appearance fees are typically booked in an hourly format, or in pre-decided block increments (For example after a subpoena, your attorney requests your clinician be at court from 9am-12pm on a given day). If you reserve a block of time, you MUST pay for the entire reserved block regardless of whether the clinician participates in the entire time block, or if court ends up being shorter. This is because the clinician has set aside this specific time for you. *(If there is a situation where there is an emergency and the clinician cannot attend court last minute, fees do not apply)*<br><br>You must also pay for any additional time that the clinician participates in court if | Rate for Legal Fees is calculated at double the clinician's standard 45 minute pro-rated psychotherapy fee, but billed in hour increments for appearances:<br><br>Interns- $266.67 per hour ($4.44 per min)<br><br>Post-Masters Clinicians- $400 per hour ($6.67 per min)<br><br>Licensed Clinicians- $480 per hour ($8 per min)<br><br>Clinical Director- $800 per hour ($13.33 per min)<br><br>**COURT PREPARATION / MISC. LEGAL** fees are typically billed per minute. This includes creating documents for a court proceeding or for legal use, reviewing records and preparing documents, communication with legal counsel, reading/reviewing legal documents.<br><br>**COURT APPEARANCE** fees are typically booked in |

| | | |
|---|---|---|
| | they are requested or compelled to participate for longer than the agreed upon time block. Extra time will be billed in additional half hour increments. (If your clinician is scheduled to appear from 9am-12pm and court goes until 12:45pm, you will be billed for an additional hour. If court goes until 12:20pm, you will be billed for an additional half an hour).<br><br>*You must pay half of the reserved time block for any court appearances BEFORE the court date. The other half is due the day of court.*<br><br>It is the client's responsibility to make their clinician aware if they anticipate any changes to their court date/time. | hourly or block format. This includes court testimony, deposition, and travel time. |
| Court Related Fees and Legal Fees for Clinical Director | Court appearances for Paris Goodyear-Brown are protected in half-day (four hour) increments. The minimum fee of $3200 for the first half day of court time is due prior to the date of the court appearance. The protection of the full four hours precludes services being offered to other clients during that time and since the full four hours has been protected for the client, no part of that initial fee is refundable. If more time is needed, the fees will be prorated in half hour increments based on the Legal Fees above. | |
| Total Estimate: | This Good Faith Estimate explains your therapist's rate 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 Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.