McDonald
COUNSELING

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PRIVATE PAYING FOR THERAPY SERVICES FEE ESTIMATE

Please keep this for your personal records.

Clients may choose to pay out-of-pocket for services for a variety of reasons. This form is notification of a client choosing to pay out-of-pocket for services under one of the following circumstances, in addition to potentially receiving Sliding Scale or Pro Bono Services, which will also be outlined:

__Client currently does not have an insurance plan and wishes to pay for services out-of-pocket.

__Client currently does have an insurance plan that provider is out-of-network with and wishes to pay for services out-of-pocket.

__Client currently does have an insurance plan that provider is in-network with, but wishes to forgo insurance claim submissions and pay for services out-of-pocket.

Definition of Sliding Scale and Pro-Bono Services

Sliding Scale and Pro Bono rates are available for clients with financial difficulties who are unable to render payment for services under normal rates. Clinicians can dictate sliding scale rates and take on pro bono clients as they please. Sliding scale rates allow clients to pay based upon their income; allowing for the client to continue paying their monthly bills and necessary expenses without as much pressure compared to paying regular rates. Pro bono rates are generally given in the form of a number of no payment sessions with the understanding that a sliding scale fee is the aim to help the clinician recoup some costs associated with seeing a client.

Patient Rights

In accordance with Title I of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Services Act (PHS), Part E, this disclosure of patient protections against surprise bills ensures that consumers know their rights and ability to dispute. For consumers who get coverage through their employer (including a federal, state, or local

government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning January 2022, these rules will:

- Ban surprise billing for emergency services. Emergency services, even if they're provided out-of-network, must be covered at an in-network rate without requiring prior authorization.
- Ban balance billing and out-of-network cost-sharing (like out-of-network co-insurance or copayments) for emergency and certain non-emergency services. In these situations, the consumer's cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
- Ban out-of-network charges and balance billing for ancillary care (like an anesthesiologist or assistant surgeon) by out-of-network providers at an in-network facility.
- Ban certain other out-of-network charges and balance billing without advance notice. Health care providers and facilities must provide consumers with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer.

For consumers who don't have insurance, these rules make sure they'll know how much their health care will cost before they get it, and might help them if they get a bill that's larger than expected.

Good Faith Estimate of Services

In accordance with the "No Surprises Act", Section 2799B-6 of the Public Health Service Act, set to go into effect 01/01/2022, healthcare providers are required to provide a "good faith" estimate of expected charges for services to individuals not enrolled in a plan or coverage or a federal health program, both orally and in writing. This paperwork serves as an in writing "good faith" estimate for services rendered.

As part of this paperwork, you will also receive a master list of *most* potential CPT codes that could prospectively be billed and their <u>full</u> pricing so you will reasonably know the absolute most you could be paying for any given service. Given the nature of therapy services, typically exact estimates are difficult to predict due to not knowing severity of symptoms, recommended frequency of services, length of time of services, and any other variables.

Good Faith Estimate for Services

Provider Name and NPI	Caitlin McDonald, LMHC; 1982261798
Practice Name and Location	McDonald Counseling, LLC; 7345 W. Sand Lake Road, Suite 303, Orlando, FL 32819
Provider Tax ID	83-1401979
Client Name	
Client DOB	
Client Address	
Client Phone	
Client E-mail	
Insurance	N/A
Diagnosis Code	
Estimate of Service Length	Varies; typically weekly/bi-weekly sessions for a minimum of 6-12 months. Weekly sessions for a period of 12 months will be used for this estimate.
CPT Codes Utilized	90791, 90834, 90837
Fee Estimate 90791 - Diagnostic Evaluation	$125.00
Fee Estimate 90834/90837 - Individual Therapy	$125.00
Fee Estimate - Missed appointment/no show	$75.00 (if applicable)
Total Estimate	$6200.00 (weekly); $3125.00 (biweekly)

Disclaimer

This “good faith” estimate shows the costs of services that are reasonably expected for your healthcare needs. This estimate is based on the information known at the time the estimate was created. The 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. If this happens, federal law allows you to dispute the bill. If you are billed for significantly more than this “good faith” estimate, you have the right to dispute the bill. You can contact us and notify us that the charges are higher than the “good faith” estimate and ask us to update the bill or the estimate. You can also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process,

you must start the process within 120 calendar days 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 provider, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-877-696-6775.

Sliding Scale:

Rate: _____

Re-Evaluation Date: _____

Pro Bono:

Re-Evaluation Date: _N/A_____

I understand and accept the terms and conditions surrounding private paying for services and receiving sliding scale and/or pro-Bono Services from Caitlin McDonald, LMHC or McDonald Counseling, LLC. I understand that I am receiving sliding scale or pro-bono services under the impression that I am at this time unable to afford the standard rates and that Caitlin McDonald, LMHC or McDonald Counseling, LLC. is willing to work with me to help me receive services. By signing this form, I acknowledge that, if receiving sliding scale or pro bono services, my report of my financial state is truthful and understand that I at any time may be referred out to another cost effective provider should my statements be in any way untruthful, or should an undue financial burden come upon my servicing clinician that impacts his/her ability to render services to me.

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date