37 W Fairmont Ave, Suite 317
Savannah, GA 31406
(866) 771-6261
contact@tideandbranchpsychiatry.com
tideandbranchpsychiatry.com

[ClientName]

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services. It is difficult to determine the true length of treatment for mental health care, and each client has the right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your medical practitioner/therapist, and we will collaborate with you on a regular basis to determine how many appointments/sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment. Please sign and date at your next appointment. If you have any questions, please don't hesitate to ask.

Sincerely,

Tide and Branch Psychiatry, LLC

The No Surprise Act,

Standard Notice and Consent Documents

(OMB Control Number: 0938-1401)

No Surprise Billing Protection Form:

The purpose of this document is to let you know about your protection 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 should not sign it if you did not 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 would like assistance with this document, ask your provider. Take a picture and/or keep a copy of this form for your records.

Why You Are Receiving this Form:

You're getting this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not 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 are 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 were 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 page four for your cost estimate.

Good Faith Estimate

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals and how long you would like to remain in treatment, 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? Email contact@tideandbranchpsychiatry.com

• **Questions about your rights or to start a dispute:** Contact: www.cms.gov/nosurprises or call 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 an item or service before you get it. 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-protectionsagainst-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 acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that I am 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 written notice on____________ explaining that my provider or facility is not 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 **do not** have to sign this form, but if you do not sign, this provider or facility will not treat you.

Patient Full Name	Patient Signature	Date
Guardian/Authorized Representative's Full Name	Guardian/Authorized Representative's Signature	Date

Good Faith Estimate

Table of Services and Fees

[ClientName]

CPT Code	Description	Fee for Service
90792	Initial Psychiatric Evaluation	$375
99215	Complex Medication	$300

	Management – 60 min	
99214	Medication Management – 45 minutes	$225
99213	Medication Management – 30 minutes	$165
N/A	Missed Appointment / Late Cancel	$100
N/A	Form Completion or Documentation	$30 per request
N/A	Production of Records	$30 per request
	Total Estimated Cost of Treatment:	This estimate is based on the services you are reasonably expected to need. Actual charges may vary depending on your individual needs and treatment decisions.

*Please note that Place of Service (in office vs. telehealth) is not delineated above since the charges are identical.

PATIENT OR LEGAL GUARDIAN Signature Date