Rebekah H Bragan, MMFT
604 N High St . Ste 3
Columbia . TN 38401
www.rebekahhbragan.com

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 **should not** sign this form if you **did not** 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 one is not available, your health plan might work out an agreement with this provider or facility, or an alternative provider.

See the last page for your cost estimates for the services you are seeking.

Estimate of what you could pay

Client name: _____

Out-of-network provider(s) or facility name: _Rebekah H Bragan_____.

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 pages four and five.

- ► **Review your detailed estimate.** See pages four and five 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?** You may contact Rebekah H Bragan, MMFT (under the supervision of Joanna Dixon, LMFT). at rebekahhbragan.counseling@gmail.com if you have questions about why this notice is required at this facility (and all providers nationwide).
- ► **Questions about your rights?** Contact: The Tennessee Health Professional Boards
  - ☐ **Online** at TN.gov

    https://www.tn.gov/health/health-program-areas/health-professional-boards/pcmft-board.html
  - ☐ **Email** at tn.health@tn.gov or
  - ☐ **In-person** at 710 James Robertson Parkway, Nashville, TN 37243

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-provide rs-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):

☐ **Rebekah H Bragan, MMFT**

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 understand that I am refusing some consumer billing protections under Federal law.
- I am electing to be responsible for charges of these services or paying out-of-network cost-sharing under my health plan.
- I was given a written notice on ___/___/_____explaining that this 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 received this notice either on paper or electronically.
- I recognize 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 receiving services.

IMPORTANT: You **do not** have to sign this form. By choosing not to sign this document and comply with this facilities effort to comply with the No Surprises Act, this provider **will not** be able to work with you and will provide you with recommendations to 3 alternative agencies or providers in the community who may be in network with your insurance company.

_____ or _____
Client's Signature Guardian/authorized representative's

_____ or _____
Print name of client Guardian/authorized representative's

_____ or _____
Date and time of 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.

Client name: _____

Date of Birth _____

Diagnosis: Z65.9 Problem related to unspecified psychosocial circumstances

Out-of-network provider(s) or facility name: Rebekah H. Bragan, MMFT

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 be required to pay.

GOOD FAITH ESTIMATE

TABLE OF SERVICES AND FEES

Clients Name: _____

Date of Service	Service code (CPT Code)	Description for provider Rebekah H Bragan, MMFT *under the supervision of Joanna Dixon, LMFT #1070*	Fee for Service (# of Sessions TBD as Tx progresses)
	90791	Initial Diagnostic Evaluation (≤53 minutes)	$125
	90832	Psychotherapy, 16-37 minutes (1/2 hour phone/virtual/in-person session)	$63
	90834	Psychotherapy, 38-52 minutes (standard 45 min treatment hour)	$125
	90837	Psychotherapy ≤ 53 minutes **(This fee is my standard <60 min> hourly rate & used for all prorated calculations)**	$125
	+99354	Psychotherapy 65-80 minutes **(When treatment extends beyond the standard hour)**	$175-250
	90839	Psychotherapy for a **Crisis** (30-74 minutes) (outside of therapist normal office days/hours)	$250
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$125
	90853	Group Psychotherapy	$20

	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records	$20 first 5 pages, $.50 each following page + shipping costs	$20+
	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.	