WATCH HILL
THERAPY

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket Limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost- sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to

get care out-of-network. You can choose a provider or facility in your plan's network.

Surprise Billing in Illinois
Illinois state law (Illinois Public Act 096-1523) protects you from "balance" or "surprise" bills when you receive care at an in-network facility or ambulatory surgery center from out-of-network providers who provide radiology, anesthesiology, pathology, neonatology, or emergency physician services at that in-network facility.

In these situations, you cannot be charged greater out-of-pocket expenses than you would have been for covered, in-network physician or provider services. The out-of-network provider should not send you a bill.

Exceptions to Illinois Surprise Billing Protections
You could, however, still be required to pay an out-of-network bill in certain situations. Illinois' surprise billing protections only apply to insurance plans regulated by the state of Illinois. Therefore, if your insurance plan is not regulated by the state, you may still be billed for these out-of-network charges. Further, these protections only apply to certain out-of-network providers who are based in an in-network facility; if the facility where you receive these services itself is out-of-network, you can also receive an out-of-network bill. Similarly, these protections do not apply if you purposely choose a provider not within your insurance network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- IDFPR (the Illinois Department of Financial and Professional Regulation) at (888) 473-4858
- U.S. Department of Health and Human Services (HHS)

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.

WATCH HILL
THERAPY

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 and 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
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

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.

Estimate of What You May Pay

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 next page.

► Review your detailed estimate. See next page 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? Contact us at info@watchhilltherapy.com or call us at (872)216-2843 to explain the documents and estimates or and answer any questions, as necessary.
► Questions about your rights? Contact: IDFPR (the Illinois Department of Financial and Professional Regulation) at (888) 473-4858 or the U.S. Department of Health and Human Services (HHS)

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 Individual Therapists at Watch Hill Therapy, LLC.

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 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.

_____	Or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
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.

WATCH HILL
THERAPY

GOOD FAITH ESTIMATE: TABLE OF SERVICES AND FEES
FEDERAL TAX ID: 46-1159298, GROUP NPI#: 1003150756, INDIVIDUAL NPI#:

Client Name: _____

Date of Birth: _____

Diagnosis: TBD – a diagnosis will be given after an appropriate clinical assessment

Out-of-network provider(s) or facility name: Watch Hill Therapy, LLC

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.
Service code

Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
90791	Initial Diagnostic Evaluation	$
90834	Psychotherapy, 38-52 minutes	$
90837	Psychotherapy ≥ 53 minutes	$
90846	Family Psychotherapy without Patient Present, 50 minutes	$
90847	Family Psychotherapy with Patient Present, 50 minutes	$
Cancellation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Full Fee of the Appointment Missed: $
Production of Records		$200/hour
Legal Fees		$200/hour

Sliding Scale Fee	Determined by needs-based criteria	Needs-based determination
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. The ultimate total fee for treatment services is unknown at the outset of treatment, but will be the number of sessions multiplied by the ongoing session fee.	

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

Disclaimer

(OMB Control Number: 0938-1401)

This Good Faith Estimate shows the costs of items and services that are reasonably expected 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. If this happens, federal law allows you to dispute (appeal) the bill.

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 U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar 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 form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

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.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above:

_____ or _____

Patient Name Patient Guardian's Signature

Date _____