THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT

* *indicates a required field*

THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT (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.

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'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 complete and submit 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 complete 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 complete this form, you can contact your health plan to find an in-network provider or facility. If there is not one, your health plan might work out an agreement with this provider or facility, or another one.

Patient Information

* Patient

First name:

Middle name:

Last name:

Date of birth:

* Patient Contact Information

Street or PO box:

City, state, ZIP:

Phone number:

Email address:

Patient's contact preference:

Provider Estimate

Provider name: Teresa B. Olson, PsyD
Street address: 8354 Princeton Glendale Rd. Suite 118
City: West Chester
State: OH
ZIP code: 45069
Contact person: Teresa B. Olson, PsyD
Phone: (513) 860-3156
Email: drtess@teresaolson.com
National Provider Identifier (NPI): 1134110034
Tax Identification Number (TIN): 46-4419198

Details of Services and Items for Teresa B. Olson, PsyD

Good Faith Estimate Table of Fees and Services

90791 Initial Diagnostic Evaluation, 60 minutes $175

90832 Psychotherapy, 30 minutes $90

90834 Psychotherapy, 45 minutes $130

90837 Psychotherapy, 60 minutes $170

90785 Psychotherapy interactive complexity add-on code $25

90839 Psychotherapy for crisis, first 60 minutes $225

90840 Psychotherapy for crisis, each additional 30 minutes $120

90846 Family psychotherapy with client, 45 minutes $160

90847 Family psychotherapy without client, 45 minutes $160

99354 Prolonged service, 30-74 minutes $170

99355 Prolonged service, each additional 30 minutes $90

90853 Group therapy, 60-75 minutes $60

98966-98968 Phone call, per 10 minute unit $25

Consultation, per 10 minute unit $25

Late cancellation fee (< 24 hours notice) $75

No show fee $75

Professional time, per 10 minute unit $25
(report writing, form completion, phone calls)

Professional time, legal, per 10 minute unit $50
(a detailed fee agreement will be completed)

Return check fee $25

Support group, 60-75 minutes $60

Travel fee $40

Production of Records (https://odh.ohio.gov/wps/portal/gov/odh/home/mrpi)

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

Total Expected Charges from Teresa B. Olson, PsyD:

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.

Disclaimer

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.

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 refer to the Table of Fees and Services for the breakdown of possible fees.

► Review your detailed estimate. Please refer to the Table of Fees and Services 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 Teresa B. Olson, PsyD at (513) 860-3156.

► Questions about your rights? Contact:
https://insurance.ohio.gov/wps/portal/gov/odi/consumers/health/surprise-billing

For 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

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.

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 HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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.

* ☐ 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 Teresa B. Olson, PsyD:

By checking this, you are eSigning this form.

* ☐ 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 on [select date below] 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.

By checking this, you are eSigning this form.

* Date of Good Faith Estimate