Grace C. Riddell, LICSW, LCSW-C and Associates

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THE NO SURPRISE ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost.

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- If you schedule a health care item or service at least 3 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 3 days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

What does this mean?

As of January 1st, 2022, the Centers for Medicare and Medicaid Services (CMS) implemented a new Federal rule to protect patients from unexpected medical bills and to increase transparency between health care clinicians and patients.

This rule requires all medical and mental health clinicians to give a “good faith estimate” (GFE) to patients estimating the cost of services and how long services may last.

Your provider is required to inform you that they are an “out-of-network” provider meaning that they do not submit claims to insurance and do not get paid by insurers.

By signing this form, you acknowledge the following:

- You have made a choice to not use your health insurance and seek a provider who may be in-network with your plan.
- You may or may not pay more for a provider’s services than your health insurance plan pays.
- You will pay the provider the full cost for each service provided, as discussed.

You may request a receipt, which you can submit to your insurance company. However, please be aware that your plan might not reimburse you, the payment may be of lesser amount than what you have paid your provider and/or they might not count any of the amount you pay towards your deductible and out-of-pocket limit.

Should you choose not to sign this form, please contact your health care plan directly for more information on “out-of-network” billing or to assist you in finding in-network providers, what is covered under your plan and other provider options.

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Good Faith Estimate (GFE)

The "Good Faith Estimate" of what you could pay if you choose to enter treatment is as follows:

I, _____ understand that

Grace C. Riddell, LICSW, LCSW-C, my clinician may provide the following services:

Service	Diagnosis Code	Service Code	Fee	Quantity	Expected Cost
				TOTAL EXPECTED COST:	

Client Name: _____ **Client Date of Birth:** _____

Diagnosis: _____ **ICD Code(s):** _____

The amount provided 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.

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Confirmation of Receipt of Good Faith Estimate (GFE)

With my signature, I understand that I may be giving up some of my federal consumer protections and may have to pay more for self-pay treatment.

With my signature, I am agreeing to get the services from the clinician providing this document.

With my signature, I acknowledge that I am consenting of my own free will, including:

- I received this estimate either on paper, electronically, or by mail, at my choice.
- I fully understand that some or all of the 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 in writing before getting services.

Client's signature		Guardian/authorized representative's signature
	OR	
Print name of Client		Print name of guardian/authorized representative
Date		Date
Therapist signature		Date and time of signature

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