KairosCounseling

No Surprises Act Billing Protection Form
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Associate Marriage & Family Therapist (#141207)

This document describes your protections against unexpected medical bills. It also notifies you that you may give up certain 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 before scheduling 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 or a patient advocate. You can take a picture and/or keep a copy of this form for your records.

You are getting this notice because this provider or facility is not in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

Disclaimers about the good faith estimate: There may be additional items or services that the provider recommends as part of the course of care that are not reflected in the good faith estimate. This is only an estimate and actual services or charges may differ from the good faith estimate. This is not a contract and does not require the patient to obtain services from any the provider or facility identified in the good faith estimate.

See the next page for your cost estimate.

Good Faith Estimate

Out-of-network provider name: Mrs. Leiza Santos (AMFT 141207)
Out-of-network facility name: Kairos Counseling Center (TIN #46-2634111, NPI #1629410022)
Out-of-network facility location: 790 Mason Street, Suite 102, Vacaville, CA 95688

Date of service	Diagnosis Code	Service	Estimated amount to be billed
TBD	TBD	Intake Session (90791)	$110
TBD	TBD	Psychotherapy Sessions (90834, 90837, 90839, 90846, 90847)	$110 per session
		Total estimate of what you may owe:	**$110 per session**

► **Review your detailed estimate.** See above for total cost.

► **Call your health plan.** Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Contact your therapist at (707) 874-8463.

► **Questions about your rights?** Contact the No Surprises Help Desk at (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 the items and services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. You have the right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. The initiation of such a process will not adversely affect the quality of health care services furnished to the patient.

By signing, I understand that I'm giving up my federal protections and may pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from: Mrs. Leiza Santos (AMFT 141207).

With my signature, I acknowledge that I'm consenting of my own free will, that I'm not being coerced or pressured, and:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed 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 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 or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____	_____
Name of patient	Name of guardian/authorized representative (if patient is a minor)
_____	_____
Patient's signature	Guardian/authorized representative's signature (if patient is a minor)
_____	_____
Date and time of signature	Date and time of signature (if patient is a minor)