THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

What is the No Surprises Act?

The recently initiated No Surprises Act was created to protect clients from unexpected bills for healthcare services, especially emergency services provided out-out-network. Although many of the No Surprises Act's provisions are not applicable to outpatient mental health services, we are still required to provide an estimate of cost of services to those who are self-pay or out-of-network.

I've already received the estimate of cost for services in my onboarding documents– why am I getting this notice now?

You're receiving this notice because based on your payment status you are considered self-pay (either uninsured or insured but choosing to self pay), you are working with a clinician who is not credentialed with insurance, or your insurance is out of network with Serenity Mental Health Services. Out-of-network means Serenity Mental Health Services does not have a contract with your plan to provide services. Engaging in care with out of network providers may cost you more than if you were to use a provider who has a contract (is in-network) with your plan.

What do I need to do now?

Below you will find information we need to collect and provide per this regulation. This estimate is not a contract and does not obligate you to obtain any services from Serenity Mental Health Services, nor does it include any services rendered to you that are not identified here. This Good Faith Estimate (GFE) is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits.

The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your treatment team. Please reach out at any time with questions regarding this form or questions on the No Surprises Act by contacting Nina Golemi, LPC directly at 920-322-5483 or nina@serenitytherapyclinic.com.

Client name:

Client date birth:

Client full mailing address:

Client telephone number:

Client email address:

Client diagnosis:

Z65.8 Other Problem Related to Psychosocial Circumstances

(PLEASE NOTE: This diagnosis is only to satisfy the federal requirement for this form. It is impossible and unethical to provide a diagnosis for new clients prior to beginning treatment, but in order to satisfy the requirements for this GFE we give all new clients a provisional or "possible" diagnosis of "Z65.8 Other Problem Related to Psychosocial Circumstances (COVID-19 virus pandemic)." This can be changed later if needed.)

Recommended Frequency

Serenity Mental Health Services is an outpatient private practice that offers individual therapy, family therapy, couples therapy, and group therapy. You may jointly determine the frequency of sessions with your assigned clinician. The typical rate of sessions includes one (1) intake evaluation that lasts approximately 90 minutes with weekly sessions thereafter.

Recommended treatment type/ primary services to be scheduled: Possible Service

Type(s) and their CPT Codes:

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name:_____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	
	90832	Psychotherapy, 30 minutes	
	90834	Psychotherapy, 45 minutes	
	90837	Psychotherapy ≥ 53 minutes	
	90846	Family Psychotherapy without Client Present, 50 minutes	
	90847	Family Psychotherapy with Client Present, 50 minutes	
	Total Estimate:	This Good Faith Estimate explains the 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 amount below is only an estimate; and is not 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. Costs are identical for in-person and virtual sessions.

How long you desire to engage in therapy and how often you attend sessions will be influenced by many factors including: Your schedule and life circumstances - Ongoing life challenges - The nature of your specific challenges and how you address them- Personal finances etc.

You and your treatment team will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/or a new "Good Faith Estimate" will be issued should your frequency or needs change.

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. By using these services, you understand you are not planning on using your insurance such as personally seeking reimbursement using a superbill. You are, however, more than welcome to use your HSA/FSA accounts for payment. You are responsible for understanding your own insurance benefits to include the co-pays and deductibles coverages available to you by choosing to work with a mental health provider within your insurance company's network. Those amounts may or may not be less than the fees you are agreeing to pay Serenity Mental Health Services. Your signature on this GFE indicates your waiver of insurance benefits and paying the out-of-pocket fees as listed above.

At any time, you may request Out of Network Billing statement if applicable(s. This statement will include Dates of Service, Billing Codes, and Diagnostic Codes. You may choose to submit these statement(s) to your insurance company to request full or partial reimbursement. Your signature on this GFE indicates that the reimbursement decision is that solely of your insurance provider and Serenity Mental Health Services in no way guarantees or has authority in this reimbursement decision.

You may contact us to discuss any issues/concerns with billing.

Provider Information

Provider type: Outpatient Mental Health Facility

Provider Name: Serenity Mental Health Services, LLC

Location: 818 West St., STE 814, Watertown, WI 53094

HIPAA secure Video through Google Meet/EHR Telehealth if virtual

Phone number: 920-545-4357

Provider EIN: 83-4666469

Provider NPI: 1285290692

Important Items to Consider

Based on the possible diagnosis, primary services provided, and the frequency these primary services will be engaged, the above stated fees are the expected maximum charges. This estimated cost is valid for 12 months from the date of the Good Faith Estimate (GFE).

I understand that as an informed consumer, it is in my best interest to contact my

health insurance plan/provider. They may have better information about what's covered under my plan and can possibly provide different provider options that are in-network if applicable and may save me money.

I have read and understand this Good Faith Estimate. This Good Faith Estimate shows the costs of items and services that are reasonably expected for my health care needs. 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. I could be charged more if complications or special circumstances occur. If this happens, federal law allows me to dispute (appeal) the bill.

If I am billed for at least $400 more than this Good Faith Estimate, I have the right to dispute the bill.

I understand that I may contact the facility listed to let them know the billed charges are higher than the Good Faith Estimate. I understand I 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.

I understand that I may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If I choose to use the dispute resolution process, I must start the dispute process within 120 calendar days of the date on the original bill. I understand there is a $25 fee to use the dispute process. If the agency reviewing my dispute agrees with me, I will have to pay the price on this Good Faith Estimate. If the agency disagrees with me and agrees with the facility, I will have to pay the higher amount. I understand I may go to the below website to learn more and get a form to start the process www.cms.gov/nosurprises or call HHS at (800) 368-1019. I understand if I have questions or for more information about my right to a Good Faith Estimate or the dispute process, I may visit www.cms.gov/nosurprises or call (800) 368-1019.

I understand that it is recommended that I store a copy of this Good Faith Estimate for my records. I may also request my provider provide me a copy of this Good Faith Estimate.

Client Name: _____ Date of Birth:_____

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____Date: _____