NO SURPRISES ACT CONSENT FORM

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BRIDGING THE BALANCE, LLC

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 are not required to sign this form and should not sign it if you did not 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 would like assistance with this document, please ask your provider or a client advocate. Please save and keep a copy of this form for your records.

YOU ARE RECEIVING 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.

Receiving care from this provider or facility could cost you more.

If your plan covers the item or service you are receiving, 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 client advocate if you need help knowing if these protections apply to you.

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. Please contact your health plan for more information.

You should not sign 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 sign 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.

FEDERAL TAX ID: 83-3139193
NPI#: 1104230184

More details about your estimate

Out-of-network provider(s) or facility name:

- Brandy K. Nicholson, Ph.D. LPC NCC CCMHC RPT
- Bridging the Balance, LLC, 4989 North Main Street, Suite 106, Acworth, GA 30101

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 and does not include any unknown or unexpected costs that may arise during treatment. The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

PLEASE CONTACT YOUR HEALTH PLAN TO FIND OUT HOW MUCH, IF ANY, YOUR PLAN WILL PAY AND HOW MUCH YOU MAY HAVE TO PAY.

See below for your cost estimate.

SERVICE CODE/CPT CODE DESCRIPTION	FEE FOR SERVICE
90791 Initial Diagnostic Evaluation	$200
90832 Psychotherapy, 30 minutes	$90
90834 Psychotherapy, 45 minutes	$130
90837 Psychotherapy 55 minutes	$170
^This fee is my hourly rate & used for all prorated calculations as indicated.	
90846 Family Psychotherapy without Patient Present, 55 minutes	$170
90847 Family Psychotherapy with Patient Present, 45 mins	$130
Cancellation Fee: Bridging the Balance, LLC requires a 24-hour cancellation notice	$50

**You are responsible for the fee of the missed appt. No out of network benefits for this.

Legal Fees/court appearance	$1,500/half-day
Legal Fees/additional time including travel time	$375/hour over half-day

TOTAL ESTIMATE: THIS GOOD FAITH ESTIMATE EXPLAINS YOUR COUNELOR'S RATE FOR EACH SERVICE PROVIDED. YOUR COUNSELOR WILL COLLABORATE WITH YOU THROUGHOUT YOUR TREATMENT TO DETERMINE HOW MANY SESSIONS AND/OR SERVICES YOU MAY NEED TO RECEIVE THE GREATEST BENEFIT ON YOUR DIAGNOSIS(ES)/PRESENTING CLINICAL CONCERNS.

**If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

Out-of-network provider(s) or facility name: Bridging the Balance, LLC

►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 above.

►Review your detailed estimate. See above 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 the Brandy K. Nicholson at 470-745-2775

►Questions about your rights? Contact: The Georgia Secretary of State at www.sos.ga.gov or 404-656-2881

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.

More information about your rights and protections:

Throughout your treatment, the provider may recommend additional items or services as part of your treatment that are not reflected in this estimate. These would need to be scheduled separately with your consent and the understanding that any additional service costs are in addition to the Good Faith Estimate.

If your needs change during treatment, your provider should supply a new, updated Good Faith Estimate to reflect the changes to treatment, and the accompanying cost changes.

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.

The Good Faith Estimate is not a contract between provider and client and does not obligate or require the client to obtain any of the listed services from the provider.

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) 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 (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.

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 (select all that apply):

- Brandy K. Nicholson, Ph.D. LPC NCC CCMHC RPT
- Bridging the Balance, LLC, 4989 North Main Street, Suite 106, Acworth, GA 30101

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 receiving services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you.

_____ _____

Client Name Client Date of Birth

_____ _____

Individual or Legal Representative (please print) Date

_____ _____

Signature of Individual or Legal Representative Date

The following counselor has reviewed this information with the responsible party.

_____ _____

Dr. Brandy K. Nicholson Date

Ph.D. LPC NCC CCMHC RPT

#LPC010754

4989 N. Main St., Ste 106
Acworth, GA 30101
Office: 470-745-2775
Fax: 470-745-2777
https://bridgingthebalance.com

Client Initials: _____