# Doc Todd Love - No Surprises Act (2 of 2)

**THE NO SURPRISES ACT**

**STANDARD NOTICE AND CONSENT DOCUMENTS**

(OMB Control Number: 0938-1401) *(r1)*

**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 potentially pay more for out-of-network care.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or print and/or keep a copy of this form.

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**IMPORTANT:** ***You aren't required to sign this form and shouldn't sign it if you didn't 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'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.***

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You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan. You could also be getting this notice if you are *choosing to not use your health insurance*, or *do not currently have health insurance*.

**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 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. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** 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 isn't one, your health plan might work out an agreement with this provider or facility, or another one

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**Estimate of what you could pay**

Out-of-network provider(s) or facility name: **Terrence Love, PsyD, LPC // *Doc Todd Love, 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 further below in this document.

▶ **Review your detailed estimate.** See information below 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 *Todd Love at 706-383-7401*

▶ **Questions about your rights?** Contact the *Georgia Secretary of State, 214 State Capitol, Atlanta, GA 30334 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**

Visit www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf) for more information about your rights under federal law.

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**GOOD FAITH ESTIMATE**

**LIST OF SERVICES AND FEES**

Listed below are the Service Codes **(CPT Code), Descriptions, and Fee's for the services offered by this provider. (***Note that the total number of services will be determined as you progress with your treatment)*

(90791) Initial Diagnostic Evaluation:

- $140

(90834) Psychotherapy, 38-52 minutes:

- $110

(90837) Psychotherapy ≥ 53 minutes:

- $125 ***(This is the standard session rate, and is used for all prorated calculations)***

(90846) Family Psychotherapy without Patient Present, 50 minutes:

- $125

(90847) Family Psychotherapy with Patient Present, 50 minutes:

- $125

Cancellation Fee for appointments cancelled with less than 24hrs notice:

- $62.50 *(1/2 full fee)*

Cancellation for missed/skipped appointments or same-day cancellations:

- $125 *(full fee)*

Paperwork services, such as letters to an attorney, documentation for school or work related needs, or other requested forms:

- $100 fee, plus $50 per half-hour for any additional time required beyond 60 minutes

Minor court proceedings (testifying, depositions, etc.), interventions, etc.

- $500 fee, plus the standard hourly rate ($125) for all time involved *(preparation, travel, attendance, etc)*

Major court-related services, such as expert witness testimony:

- *Priced on an individual, per-case, basis.*

**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.***

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**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:

*Provider Name:* ***Terrence Love, PsyD, LPC*** *(Licensed Professional Counselor)*

*Practice Name:* ***Doc Todd Love, LLC***

*Address:* ***585 Research Dr, Suite D Athens, GA 30605***

*Phone:* ***(706) 383-7401***

*Email:* ***todd@doctoddlove.com***

*National Provider Identifier (NPI):* ***1053707943***

*Taxpayer Identification Number (TIN):* ***47-2947776***

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 the date of this document 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.

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

**Print and keep a copy of this form. It contains important information about your rights and protections.**