MATTERS OF THE HEART COUNSELING
MATTERSOFTHEHEARTCOUNSELING.ORG
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HENDERSONVILLE, TN 37075 GOODLETTSVILLE, TN 37072

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 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.

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.

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 toyou.

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 **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 one is not available, your health plan might work out an agreement with this provider or facility, or an alternative provider.

See the last page for your cost estimates for the services you are seeking.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: Matters of the Heart Counseling,

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 on page four.

► **Review your detailed estimate.** See page four 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?** You may contact Joanna Dixon, LMFT at Joanna@MOTHcounseling.org or Jinny Glasco, LCSW at Jinny@MOTHcounseling.org if you have questions about why this notice is required at our facility (and all providers nationwide).

► **Questions about your rights?** Contact: The Tennessee Health Professional Boards

☐ **Online** at TN.gov https://www.tn.gov/health/health-program-areas/health-professional-boards/pcmft-board.html

☐ **Email** at tn.health@tn.gov or

☐ **In-person** at 710 James Robertson Parkway, Nashville, TN 37243

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 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.

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):

☐ _____ **(provider)**

☐ **Matters of the Heart Counseling**

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 understand that I am refusing some consumer billing protections under Federal law.
- I am electing to be responsible for charges of these services or paying out-of-network cost-sharing under my health plan.
- I was given a written notice on ____/____/____ explaining that this provider or facility is not 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 received this notice either on paper or electronically.

- I recognize that some or all amounts I pay might not count toward myhealth 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 **do not** have to sign this form. By choosing not to sign this document and comply with this facilities effort to comply with the No Surprises Act, Matters of the Heart Counseling, and our providers **will not** be able to work with you and will provide you with recommendations to 3 alternative agencies or providers in the community who may be in network with your insurance company.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ or _____

Print name of patient | Print name of Guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Patient name: _____ **Date of Birth:** _____

Diagnosis: _____

Out-of-network provider(s) or facility name: **Matters of the Heart Counseling**

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows thefull 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 be required to pay.

Each individual provider's rates for services are listed on our website and each provider has a table of services and fees with service codes to provide to you should you require them for insurance submission.