Embodied Insight Counseling, LLC
Good Faith Estimate
For Health Care Items and Services

Effective January 1, 2022, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request, they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

Good Faith Estimate 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 (e.g., emergency or crisis services). You could be charged more if special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. You may contact the health care provider 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. 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, 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 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. **Take a picture and/or keep a copy of this form in a safe place, it contains important information about your rights and protections.**

Surprise Billing Protection Form

The purpose of this document is to let you know about your protection 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 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 isn't in your health plan's network. This means the provider doesn't have an agreement with your health plan. Getting care from this provider 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:

- When you get emergency care from out-of-network providers and facilities, or
- 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. If there isn't one, your health plan might work out a temporary agreement with this provider or another one.

►**Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

►**Call your health plan.** Your plan may have better information about how much you will 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?** Call Shelby Dwyer, 617-616-8491, to explain the documents and estimates to you and answer any questions, as necessary.

►**Questions about your rights?** 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.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to receive services from Shelby Dwyer, LMHC, LCMHC, LCPC, LPC, CYT and Embodied Insight Counseling, LLC.

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 written notice on [*enter date of notice*] explaining that my provider 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.
- 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 in writing before getting services.

IMPORTANT: You **don't** have to sign this form. You can choose to get care from a provider in your health plan's network.

Patient's signature: ____

Print name of patient: ____

Date and time of signature: ____

Guardian/authorized representative's signature: ____

Print name of guardian/authorized representative: ____

Date and time of signature: ____

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. This estimate does not include any atypical services such as emergency or crisis services that may arise in treatment. Please refer to the intake documentation that you signed at the start of our work together for more information related to other fees. This form 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. Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Client name:	**DOB:**

Diagnosis code, primary:	
Diagnosis code, secondary (if applicable):	
Diagnosis code, tertiary (if applicable):	

Service Code	**Service Type/Description**	**Frequency**	**Fee**
90791	Initial assessment/Intake	Once per year	$250
90837	60min individual psychotherapy	Weekly for a total of 46 weeks (annually)	$200
		Total annual estimate of what you may owe:	$

Individual Provider: Shelby Dwyer, LMHC; NPI 1629564133; Tax ID 83-4456449

Organization/LLC: Embodied Insight Counseling; NPI 1477123248; Tax ID 87-1209820

Provider Signature: ______________________________ **Date of Estimate:** ______________

Client Signature: ______________________________ **Date:** ______________