New Heights
Counseling & Consulting, LLC
Finding Answers - Reaching Aspirations

January 1, 2022

Dear Client:

You are receiving this notification because you are either self-pay with New Heights Counseling or New Heights Counseling is out of network with your insurance.

As of January 1, 2022, we are required by Federal Law via the No Surprises Act, to provide you with a “Good Faith Estimate” of cost at least annually. The attached document includes an overview of the law and a good faith estimate specific to your insurance situation and provider.

Please note that due to the fact that the frequency and duration of therapy can change throughout the course of treatment, we have decided to provide you with an estimate of what the cost should be should you attend therapy every week for one year. We recognize that most people will not attend therapy at this frequency and duration, but want to be as transparent as possible.

We ask that you review the last 2 pages and sign and return it to us.

If you have any questions, please do not hesitate to reach out to me at 850-757-1552.

Thank you for your time and attention to this matter,

Colleen Wenner-Foy, Owner, LMHC

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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 healthcare 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.

See the next page for your cost estimate.

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Estimate of what you could pay

Patient Name:	**DOB:**	**Therapist:**

Out-of-network provider(s)or facility name/tax ID/NPI number: New Heights Counseling & Consulting LLC (Tax ID: 86-1780082); Supervising Therapist Name/ NPI: Colleen Wenner-Foy, LMHC/1942788740

Provisional Diagnosis (subject to change): To Be Assessed on Date:

The amount below is only an estimate; it isn't 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.

Date of Service	Service Code	Description	Estimate Amount To Be Billed
1/1/22-12/31/22	90837	Individual Therapy Session 55 minutes	$100
		X52 weeks	$5200
		Total estimate of what you MAY owe	$5200

Other Associated Costs/ Fees:
Consultation (including /phone)/Report writing: $35 (per 15 minutes)
Appearance at court on your behalf: $2,500 per day to reserve therapist time and must be paid in full 30 days prior to the expected court date
Missed Appointments/Late Cancel within 24 hours of the Appointment: $100
Bounced Checks: $25 each

Other Associated Costs/ Fees:
Consultation (including /phone)/Report writing: $35 (per 15 minutes)
Appearance at court on your behalf: $2,500 per day to reserve therapist time and must be paid in full 30 days prior to the expected court date
Missed Appointments/Late Cancel within 24 hours of the Appointment: $100
Bounced Checks: $25 each

►**Review your detailed estimate.** See above 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 New Heights Counseling, Billing Manager, Samantha Holister at 850-757-1552

►**Questions about your rights?** Contact the No Surprises Helpdesk at www.cms.gov/nosurprises or 1-800-985-3059

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.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan: Contact your health plan for more information on in network providers.

More information about your rights and protections

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

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 get the items or services from (select all that apply):

X Therapist Name:

X New Heights Counseling and Consulting, LLC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also was given a written notice on the following date 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. Date:

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 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. You can choose to get care from a provider or facility in your health plan's network.

Parent's/Guardian Signature:

Print Parent's/Guardian:

Print Name Of Patient:

Date/Time of Signature:

Take a picture and/or keep a copy of this form. It contains information about your rights/protections.