WIDE AWAKE LIVING

Clients Rights to a Good Faith Estimate of Healthcare Services

Updated January 8, 2024

Effective Date: January 1, 2022

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that I notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, I am required to provide you with a Good Faith Estimate of the cost of services (see attached standard "2024 Table of Services and Fees"). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, you will find a fee schedule for the services I offer. I will collaborate with you on a regular basis to determine how many sessions you may need.

It is a Federal requirement that I inform each client of their protections under the No Surprises Act. This document is one of several avenues that I am using to inform clients. If you have any additional questions, please don't hesitate to ask.

With gratitude and sincerity,

Jackie Werboff, *Owner*
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Licensed Mental Health Counselor (MH 16535)
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(904) 257-5025

2024 Table of Fees and Services

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical

Service Code (CPT Code)	Description	Fee for Service (the number of sessions will be determined as treatment progresses)
90791	Initial Intake & Diagnostic Assessment	$135
90837	Psychotherapy, 53-60 minutes	$135
90837	Psychotherapy, greater than 60 minutes	$2.50/minute, for example: $187.50 for 75 minutes, $225 for 90 minutes, etc.
90846	Family Psychotherapy **without** client present, 53-60 minutes	$135
90847	Family Psychotherapy **with** client present, 53-60 minutes	$135
98966-98968	Telephone Assessment & Management	$2.50/minute, minimum of 15 minutes
98970-98972	Online Digital Evaluation & Management (Responding to Email & Text Messages)	$2.50/minute, minimum of 15 minutes
Session Cancellation & Reschedule Fee	With the exception of emergencies I require a 24 hour notice for session cancellation and/or reschedule. If the client is feeling ill the client may attend their session via HIPAA compliant telehealth platform.	Client Responsible for the Missed Appointment Fee - $100
Production of Records	Florida Statute 395.3025	May not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested.
Returned Checks	Returned Checks	$25/check

Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. I 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.

Updated January 8, 2024

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain service sat an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're **never** required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities Directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

(1) Jackie Werboff, owner of Wide Awake Living, LLC by calling (904) 257-5025 or emailing jackie@wideawakecounseling.com

(2) The Florida Board of Health: The Health Care Complaint Portal allows consumers to file a complaint with the appropriate state agency. You will be asked a series of questions to help identify the nature of your complaint. After you have answered all of the questions, you will see a summary page with instructions on how to file your complaint. Visit https://mqa-flhealthcomplaint.doh.state.fl.us

For more information about your rights under the "No Surprises Act" Federal law, you may also visit:
https://www.cms.gov/files/document/model-disclosure-notice-patient-protectionsagainst-surprise-billing-providers-facilities-health.pdf