Alliant Therapy Group, PLLC

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Edmonds WA 98020
425-361-7987

9. No Surprises Act: Standard Notice and Consent

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 to receive services at our out-of-pocket rate option rather than going
through your insurance.

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. All forms are downloadable.

You're getting this notice because this provider or facility isn't in your health plan's network or you are choosing to pay out of pocket.

EXCEPTIONS FOR OUT-OF-POCKET/PRIVATE PAY SERVICES

By paying out of pocket, you understand that the cost per visit is the flat rate discussed prior to scheduling and outlined in the fee table at the end of this document. Out-of-pocket services are not billed the same as out-of-network benefits. Whether you have no health insurance plan or a plan that we are not in network for, if you are paying out of pocket with Alliant Therapy Group, you are not utilizing any out-of-network benefits if you do have insurance, and payments do not go toward an insurance deductible.

This document also serves as an acknowledgment of opting out of your insurance mental health benefits even if Alliant Therapy Group may be contracted with your carrier. You are choosing not to utilize any insurance benefits plan and agree to pay for services accessed out of pocket.

SIGNATURE:

DATE OF SIGNATURE:

INSURANCE OR OUT-OF-NETWORK COVERAGE versus OUT-OF-POCKET PROTECTIONS

If your insurance 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 these protections under the law by not using insurance.

• You may owe the full costs billed for items and services received as outlined in the fee schedule below.

• 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 if you would like to choose an in-network provider or facility.

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. You may also choose to pay out of pocket for our services.

DETAILS ABOUT FEES

FACILITY OR PROVIDER INFORMATION

Alliant Therapy Group, PLLC

FEDERAL TAX ID: 82-1178110

GROUP NPI#: 1588197628

CLIENT INFORMATION

FULL LEGAL NAME:

DATE OF BIRTH:

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.

► See fees listed below for the cost for each item or service. You must calculate the total cost by estimating the number of visits you believe is accurate for yourself.

► If you have questions about this notice, or feel you have been billed in error, email contact.alliant@gmail.com

► Questions about your rights? Contact: State of Washington Department of Health and Human Services at (360) 753-1761

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.

Keep a copy of this form. All forms are downloadable and accessible from your file. This contains important information about your rights and protections.

FEE SCHEDULE

The amount below is a fee schedule of actual cost based on level of counselor, and isn't an offer or contract for services. This fee schedule shows the full actual costs of the items or services listed.

These costs are what you will be billed per service accessed and are accurate if you are choosing to pay out of pocket.

This fee table does not obligate you to obtain any services from the provider(s) listed, nor does it include any services that may be recommended during treatment to you that are not identified here.

Alliant Therapy Group, PLLC is a training clinic with all levels of counselors and we make every effort to match clients with the provider that we believe would be the best fit for care. You have the right to request any counselor by name or skill level and we will do our best to match you accordingly, though due to your scheduling needs or our counselor availability that may not always be possible. When not possible, we will offer our clinical recommendations on who we believe would be the best fit, and you may decide whether or not you'd like to receive services with that provider. We will also inform you of the level of counselor so that you may estimate your costs.

GOOD FAITH ESTIMATE

TABLE OF SERVICES AND FEES

Service codes (CPT Code), Description, and Fees for Service (Number of Sessions Will Be Determined as We Progress):

90791 Initial Diagnostic Evaluation
- $155

90832 Psychotherapy (16-37 minutes)
- Intern Resident: $45
- Associate License: $75
- Fully Licensed: $85

90834 Psychotherapy (38-52 minutes)
- Intern Resident: $65
- Associate License: $105
- Fully Licensed: $120

90837 Psychotherapy (53-60 minutes) (This fee is the hourly rate & used for all prorated calculations as indicated)
- Intern Resident: $80
- Associate License: $135
- Fully Licensed: $155

90839 Psychotherapy for a Crisis (30-74 minutes)
- Intern Resident: $125
- Associate License: $215
- Fully Licensed: $230

+90840 Psychotherapy for a Crisis (add-on code for each additional 30 mins)
- Intern Resident: $65
- Associate License: $115
- Fully Licensed: $125

90846 Family Psychotherapy without Patient Present (45 minutes)
- Intern Resident: $80
- Associate License: $135
- Fully Licensed: $155

90847 Family Psychotherapy with Patient Present (45 minutes)
• Intern Resident: $80
• Associate License: $135
• Fully Licensed: $155

90853 Group Psychotherapy
• $45

98966-98968 Telephone Assessment & Management
• Prorated based on the amount of time spent at hourly rate

98970-98972 Online Digital Evaluation & Management (Responding to Email & Text Messages)
• Prorated based on the amount of time spent at hourly rate

Cancelation Fee
• Your Therapist Requires a 24-Hour Cancelation Fee. You are Responsible for the Fee of the Appointment Missed, billed at hourly rate

Production of Records
• $35

Legal Fees
• Prorated based on the amount of time spent at hourly rate

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.

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

SIGNATURE

IMPORTANT: You do not have to sign this form. If you choose not to, this provider or facility may offer referrals for possible in-network providers or facilities.

By typing your name below, you are acknowledging that this serves as your electronic signature, and:

That you've received written notice of Alliant Therapy Group's fee schedule, and that this provider or facility will not be billing your insurance or out-of-network coverage, and you are consenting to the fees associated with services at this facility.

You can end this agreement by notifying the provider or facility in writing before getting services.

Signature:

Date of Signature: