Alliant Therapy Group, PLLC
200 1st Ave W Suite 400 Seattle, WA 98119
www.allianttherapy.com

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.

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, 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. This means the provider or facility doesn't have an agreement with your plan or you have no insurance plan.

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.

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

See the next page for your cost estimate.

Estimate of what you could pay

Provider(s) or facility name: **Alliant Therapy Group, PLLC**

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 listed below.

► **Review your detailed estimate.** See fees listed below for a cost estimate for each item or service.

► **Questions about this notice and estimate?** 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.

By signing, I give up my federal consumer protections and agree to the below out-of-pocket rates.

With my signature, I am saying that I agree to get the items or services from Alliant Therapy Group, PLLC.

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 was given a written notice explaining that my provider or facility will not be billing my insurance or out-of-network coverage, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically.
- I fully and completely understand that some or all amounts I pay will 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 getting services.

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

______________________________	or	______________________________
Patient's signature		Guardian/authorized representative's signature
______________________________		______________________________
Print name of patient		Print name of guardian/authorized representative
______________________________		______________________________
Date and time of signature		Date and time of signature

Keep a copy of this form. All forms are downloadable and accessible from your file.

This contains important information about your rights and protections.

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FEDERAL TAX ID: 82-1178110
GROUP NPI#: 1588197628

More details about your estimate

Out-of-network provider(s) or facility name: Alliant Therapy Group, PLLC

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 if you are choosing to pay out of pocket.**

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

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$110
	90832	Psychotherapy, 16-37 minutes	Intern Resident: $40 Associate License: $60 Fully Licensed: $80
	90834	Psychotherapy, 38-52 minutes	Intern Resident: $55 Associate License: $85 Fully Licensed: $110
	90837	Psychotherapy ≥ 53 minutes <u>(This fee is the hourly rate & used for all prorated calculations as indicated)</u>	Intern Resident: $70 Associate License: $110 Fully Licensed: $145
	90839	Psychotherapy for a Crisis (30-74 minutes)	Intern Resident: $110 Associate License: $180 Fully Licensed: $210
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	Intern Resident: $55 Associate License: $90 Fully Licensed: $105
	90846	Family Psychotherapy without Patient Present, 45 minutes	Intern Resident: $70 Associate License: $110 Fully Licensed: $145
	90847	Family Psychotherapy with Patient Present, 45 minutes	Intern Resident: $70 Associate License: $110 Fully Licensed: $145
	90853	Group Psychotherapy	$35
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (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
	Total Estimate:	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.