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Good Faith Estimate for LaTrenda Washington, MS, LPC, NCC, BC-TMH

FEID: 58-1998287
NPI: 1477101244

Client Full Name:

Client Date of Birth:

Client Email:

From our Office: Regarding the No Surprises Billing Documents

Regarding fees for LaTrenda Washington, MS, LPC, NCC, BC-TMH

We are so grateful that you have chosen us to help you/your child. We are committed to your success and growth. To that end, we will always strive to maintain a safe, open, honest environment in therapy, including honesty around what you may expect to pay. The decision to remain in therapy is always yours. That being said, the federal government is requiring that as of Jan 1, 2022, we comply with the No Surprises Act, which was finalized October 2021. Please note the intention of this law is to prevent consumers who go to a facility where you work with multiple providers (like a surgical center or emergency room) from being surprised by bills from out of network providers that they were not aware of, or they did not have a choice in selecting. To comply with the spirit of the law and our own sense of honesty and ethics, we want you to know a few things:

* LaTrenda Washington is out of network with all insurance companies.

* LaTrenda Washington's therapy fee is $120.00 per one-hour session, regardless of who or how many people are in session.

* We cannot guarantee the number of sessions that will be required to complete therapy, (especially before we have met with you). Your therapist will speak with you more about this when you meet.

* If you have any questions, you always have the right to discuss fees with your therapist or our office manager, Tamara Onley (770-399-6333).

* 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.

* You always have the right to terminate therapy at any time.

* You also have the right to choose to see an in-network provider. Depending on your insurance, an in-network provider MAY be less costly to you. We will be happy to help you find a provider should you need help.

* I am not an attorney, but it is my understanding that by signing this document, the ONLY consumer right you are relinquishing is the right to seek arbitration for a surprise charge. For example, it is my understanding that if you ever receive a charge greater than $400 over our estimate, you have the right to dispute it.

* Please note that in one place, the OMB document states you lose your rights but, in another place, it says you lose SOME of your rights.

* Be aware the regulations around this act are changing and evolving but we have to apply the law now, regardless.

* Contact The Secretary of State of Georgia for questions about your rights under the law.

* You can contact: 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.

* Please re-read my first paragraph - we strive for an open, honest, helpful and safe environment for you to work with us.

Now that we have explained our position, The remainder of this document explains your rights under the new No Surprises Act. Please realize, again, that we comply with this law, but you will not experience most of these circumstances with us.

THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT DOCUMENTS

OMB Control Number: 0938-1401

SURPRISE BILLING PROTECTION FORM

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 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. See the next section for your cost estimate.

Estimate of What You Could Pay

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 that follows.

* Review your detailed estimate for a cost estimate for each item or service.
* Call your health plan. Your plan may have better information about how much of these services are reimbursable.

* Questions about this notice and estimate? Contact your therapist or the Office Manager, Tamara Onley (770-399-6333), to explain the documents and estimates to the individual and answer any questions, as necessary.

* Questions about your rights? Contact the Georgia Secretary of State (www.sos.ga.gov).

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.

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.

Good Faith Estimate

List of Services and Fees

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.

- Diagnostic Evaluation - 90791 - $120.00
- Psychotherapy (38-52) - 90834- $120.00
- Family Therapy w/ the client - 90847 - $120.00
- Assessments (**not including session fee**) –
  16PF Fifth Edition - $30
  MCMI-III - $75
  MMP-2 Adult Clinical System-Revised $75
  MMPI-A Interpretive Report - $60
  T-JTA Criss Cross - $75
  T=JTA Individual - $40
  Marital Satisfaction Inventory - $30
  Prepare-Enrich - $35
- Cancellation Fee (24-hour notice required) - $40.00
- Production of Records - Prorated based on time spent at the hourly rate plus $1 per page
- Court Fees - $1500 for 1/2 day minimum + $375 per hour for any time over 4 hours.

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 or services you may need to receive the greatest benefit based on your diagnosis and presenting clinical concerns.

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

With my signature, I am saying that I agree to get the items or services from LaTrenda Washington.

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 offered a written notice when I scheduled my first appointment 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.

* 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.