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.

Estimate of what you could pay

Patient's name: ____
Patient's Date of Birth: ___________________________________

Out-of-Network Provider: Ardeo Counseling, LLC

- **See page 5 for Estimate you may be asked to pay**
- **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 provider options.
- **Questions about this notice:** Contact Ardeo Counseling, LLC at 443.502.0385
- **Questions about your rights:** Contact 1-800-MEDICARE or Maryland Insurance Administration at (800) 492-6116

Prior authorization or other care management limits may apply:

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 items or services described in this notice from other providers who are in-network. **Please contact your plan at the number located on the back of your insurance card.**

More information about your right and protections:

Visit Center for Medicare and Medicaid Services at https://www.cms.gov/nosurprise

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:
_____Ardeo Counseling, LLC________

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 given a written notice on ________________________ 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 Vascular Surgery Associates.
- 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 towards my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying Ardeo Counseling, LLC in writing before getting services.

IMPORTANT: You don't have to sign this form. But if you don't sign, Ardeo Counseling, LLC may refuse to provide items or services. You can get care from a provider in your health plan's network. Please contact the number or website on the back of your insurance card.

______________________________ or ______________________________

Patient’s Signature | Guardian/Representative Signature

______________________________ or ______________________________

Print Name of Patient | Print Name of Guardian/Representative

______________________________ or ______________________________

Date and Time of Signature | Date and Time of Signature

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

More details about your estimate

Patient name: ____

Out-of-network provider(s) or facility name: Ardeo Counseling, LLC
Provider Name: ______________________________
Business NPI: 1386237667
Provider Tax ID: 84-4402849

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.

Estimates are based on the following fee schedule*:

Service Code	Description	Standard Fee Billed
90791	**Initial Intake, Diagnosis**	**$125**
90837	**Individual Psychotherapy 53-60 minutes**	**$105**
90834	**Individual Psychotherapy 38-52 minutes**	**$80**
90832	**Individual Psychotherapy 16-37 minutes**	**$50**
90847	**Family Psychotherapy 23-60 minutes**	**$105**

*Rates on the Fee Schedule are assessed periodically and may change. Any rate changes will be communicated via writing to current clients with at least 90 days notice prior to implementation.

Your anticipated services include one (1) intake assessment appointment (CPT: 90791) with your provider, followed by recurring psychotherapy services (CPT: 90837. 90834, or 90832). Most clients attend at a frequency of: (a) one 60-minute psychotherapy session per week, or (b) one 60-minute psychotherapy session per 2 weeks

The frequency of psychotherapy sessions that are appropriate in your case may be more or less, depending on your needs. Based on the estimated fee schedule above, the following are expected charges of psychotherapy services.

Estimate Based on ONE (1) Session per Week					
Date of Service	**Service Code**	**Description**	**Frequency**	**Cost**	**Estimated Total**
	90791	**Initial Intake, Diagnosis**	**One session**	**$125**	**$125**
	90837	**Individual Psychotherapy 53-60 minutes**	**Weekly for 50 weeks**	**$105 per session**	**$105 x 50 = $5250**
Total annual estimate of what you may owe:					**$5375**

Estimate Based on ONE (1) Session per 2 Weeks					
Date of Service	**Service Code**	**Description**	**Frequency**	**Cost**	**Estimated Total**
	90791	**Initial Intake, Diagnosis**	**One session**	**$125**	**$125**
	90837	**Individual Psychotherapy 53-60 minutes**	**Every two weeks for 50 weeks**	**$105 per session**	**$105 x 25 = $2625**
Total annual estimate of what you may owe:					**$2750**