clearhope
counseling & wellness

Notice of Compliance with The Consolidated Appropriations Act of 2021 and the “No Surprises Act”

Effective January 1, 2022, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

Note: The PHSA and GFE does not currently apply to clients who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement).
However, we are furnishing this information to all clients so that you may understand your estimated charges in the event that your health insurance expires, or you choose to become a cash pay client. These charges would also apply if you received services after the expiration of your health insurance plan and did not give us prior notification of the expiration.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care needs. The estimate is based on information known at the time the estimate was created. The good faith estimate is not a contract and services can be discontinued at any time.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could require more sessions depending on your progress. Any changes to the treatment plan will be discussed with the therapist as needed.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059. Keep a copy of this Good Faith Estimate in a safe place.

Clearhope Counseling & Wellness will ensure:

1. CHW financial agreement mentions Good Faith Estimate and No Surprises Act.
2. Client progress/intake notes document verbal disclosure, verbal discussion, and acknowledgment of the “good faith estimate” for treatment plans.
3. All Clients will sign a "good faith estimate" of the projected cost of care for the treatment plan prescribed by the therapist.

On _____(date) the therapist and client reviewed the good faith estimate based on the prescribed treatment plan. The therapist explained that insurance benefit estimation and insurance billing is done as a courtesy to the client and is not a guarantee of payment on behalf of the client.

The maximum possible client responsibility was discussed and estimated with the client as based upon the Financial Agreement form on file, insurance benefit utilization, cash pay, reduced fee, or client selection to opt-out of benefits. The therapist and client considered implications, discussed questions, and client verbally consented to the estimate.

Good Faith Estimate

Client Name:_____ Client DOB:_____

Prescribed Treatment Plan:_____

Total number of sessions in treatment plan: _____

Cost per session with insurance:_____

Estimated total cost (good faith estimate) with insurance:_____

Cost per session without insurance:_____

Estimated total cost (good faith estimate) without insurance:_____

I understand the good faith estimate outlined above and agree to this plan.

_____ _____

Client Signature Date