**Carol Miles MSW, LCSW**

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**GOOD FAITH ESTIMATE (GFE) - No Surprise Billing Notification Form (Out of Network/Self-Pay Only)**

January 2023

As of January 1st, 2022, the Centers for Medicare and Medicaid Services (CMS) instituted a new Federal rule to protect patients from unexpected medical bills and to increase transparency between health care clinicians and patients when the patient is:

* using out of network benefits rather than an in-network provider,
* when the patient doesn’t have insurance,
* or if the patient has insurance but is choosing not to use it.

As this is a new ruling, guidance is coming out over time, so this is the first version of the GFE. Some disciplines have been excluded from the GFE (such as dentists) and it is hoped that private practice LCSWs will also eventually be excluded from providing this separate document as our pricing is already transparent at the beginning of therapy, thus fulfilling the spirit of the new law which now requires that this information is provided to you in a separate document from your intake paperwork.

What IS newly required is that we must provide a written GFE with the anticipated amount of time that therapy may last rather than only discussing this verbally**. Notably, the GFE can only be an estimate, not an absolute because:**

* the duration of therapy is changeable depending on a client’s response to treatment, diagnoses that may emerge as the client’s circumstances become more evident, client compliance with the treatment recommendations, client response to the treatment, and changing circumstances of the client such as new crises or problems which can happen in a person’s life for which the client may want assistance.

Also important is that **this new law allows you to dispute the amount you owe if the cost of treatment exceeds $400 of the estimated cost provided in the GFE without being given a new Good Faith Estimate (GFE).**  The GFE is not a contract which requires you to accept treatment with me, or to remain in treatment with me. It is just information for your consideration so that there are no surprises financially for you. **You will receive a GFE from me at minimum of once per year or upon your request at any time during the year, or if the diagnosis or treatment recommendations change in a way that extends the treatment from the initial GFE.**

By signing this form, you acknowledge that:

* you have been given this GFE
* You know that you have the right to see a provider who is in network with your insurance or go to an agency that charges less than you will pay in my private practice. **Seeing someone in network often results in less total cost for your care overall.** You may change your mind to see an in-network provider if you have insurance or accept a referral to a sliding scale type of agency/provider if you find that is more helpful to you.
* **You will likely pay more for my services than your health insurance plan reimburses you due to my being out of network** and are notified that full payment is due at the time of service unless we make a different arrangement.
* Upon request, I can provide you with an invoice which you can submit to your health insurance company. **However, please be aware that your plan might not reimburse you at all even if you have out of network benefits, and the insurance payment will likely be of a lesser amount than what you have paid me. Your insurance might not count any of the amount you pay me towards your deductible and out-of-pocket limit.** Some insurance companies have tiers of out of network. If you want to confirm with your insurance company whether my services are considered allowable, you should contact the phone number on the back of your insurance card. My financial relationship is with you, not your insurance company and therefore I have no influence with what they will reimburse you.

Should you choose not to sign this form, please contact your health care plan directly for more information on “out-of-network” billing or to assist you in finding in-network provider, to explore what is covered under your plan and other provider options.

The “Good Faith Estimate” of what you could pay if you choose to enter treatment, or continue treatment, is as follows:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that

Carol Miles MSW, LCSW, my clinician, may provide the following services

EMDR Intensive Packages

6-hour program – $1,200

9 Hour Program – $1,800

Should there be a further time extension agreed upon by the client and therapist, the fee will be prorated on the hourly rate.

Additional hours available at $200/hour

I anticipate that your treatment for diagnosis code(s) \_\_\_\_TBD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

will require:

All will receive a new GFE if you are in therapy here after the initial 12 months of this document unless the law changes requriements.

**Taking into account vacations, sick time, holidays and emergencies, the number of sessions could be increased or decreased.** **This Good Faith Estimate is not intended to serve as a recommendation for treatment or a firm prediction that you may need to attend a certain number of visits as this may change during the course of treatment and the purpose of the GFE is to give you a financial prediction of estimated costs.** The number of visits that are appropriate in your case and the estimated cost for those services depends on your needs, which can be changing, and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time. You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan or the information provided to you in this Good Faith Estimate.

If there is a dispute about this estimate, you may contact the Department of Health and Human Services within 120 days of the service outlined in this estimate at the following link: <https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured>

Should you have additional questions about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call the “No Surprises” Help Desk at 800-985-3059.

With your signature below, you understand that you may be giving up some of your federal consumer protections by seeing an out of network provider and may have to pay more for self-pay treatment.

With your signature, you acknowledge that you are consenting of your own free will to accept this estimate and to receive the treatment discussed within should you wish to schedule those appointments and you have received this estimate either in paper in person, electronically or by mail at your choice.

You can end this agreement by notifying the provider in writing before receiving services.

Client’s Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature and Date Signed:

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Therapist Signature and Date signed:

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LA License number: 1845

NPI Number for Carol Miles MSW, LCSW rendering provider:

Taxpayer ID number: 84-3645407

NPI Number for Carol Miles MSW, LCSW LLC: 1871500397