Thrive Therapy Group, P.C.
42500 Hayes Road, Suite 500.
Clinton Township, MI 48038
(586)-828-1221
Fax (586) 421-4705
thrivegroup.office@gmail.com

Dear Thrive Therapy Group Patient,

In compliance with the No Surprises Act that goes into effect January 1, 2022, all healthcare providers are required to notify clients of their federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a patient elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

It is a federal requirement that we have each patient sign this form to begin/resume treatment. Please sign and date before your next appointment and return the signed document before your next appointment. If you have any questions, please do not hesitate to ask.

Thank you very much,

Dr. Amy Hanes, PsyD
Thrive Therapy Group, P.C.

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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

When you get emergency care or get treated by an out-of-network provider at anin-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Consumers who do not receive the required disclosure form or who receive a surprise medical bill after receiving care should contact their health insurer, and if they cannot resolve the issue, contact DIFS Monday through Friday 8 a.m. to 5 p.m. at 877-999-6442 or visit the DIFS website, https://www.michigan.gov/difs to file a complaint.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you isyour plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You are never required to give up your protection from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services inadvance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay anin-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network servicestoward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact: Michigan Department of Licensing and Regulatory affairs at https://www.michigan.gov/lara, Phone: 800-882-6006, Fax: 517-335-7167 or Email: **BCHS-Complaints@michigan.gov**

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.

Visit https://www.michigan.gov/difs/0,5269,7-303-13222_13250-561696--,00.html for more information about your rights under.

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.

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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 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 are getting this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not 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 are 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 **should not** sign this form if you **did not** 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 is not one, your health plan might work out an agreement with this provider or facility, or another one.

See the proceeding pages for your cost estimate.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name: Thrive Therapy Group, P.C.

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 on page four.

- ► **Review your detailed estimate.** See the following page 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?** Call Dr. Amy Hanes at 586-828-1221.
- ► **Questions about your rights?** Contact: Michigan Department of Licensing and Regulatory affairs at https://www.michigan.gov/lara, Phone: 800-882-6006.
- ► **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.

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 Thrive Therapy Group, PC.

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 am 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 **Date:**_____ 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 **do not** have to sign this form. But if you do not sign, this provider or facility might not treat you.

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

Take a picture and/or keep a copy of this form.

It contains important information about **your rights and protections.**

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FEDERAL TAX ID: 46-3774947

More details about your estimate

Patient name:

Out-of-network provider(s) or facility name: Thrive Therapy Group, P.C.

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not 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.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

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	
	90832	Psychotherapy, 16-37 minutes	
	90834	Psychotherapy, 38-52 minutes	
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	
	90839	Psychotherapy for a Crisis (30-74 minutes)	
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	
	90846	Family Psychotherapy without Patient Present, 50 minutes	
	90847	Family Psychotherapy with Patient Present, 50 minutes	
	96130-96133, 96136-96139	Psychological and Neuropsychological Testing	
	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 **$75** fee of the appointment missed
	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. telehealth) is not delineated above since the charges are identical.