



Liberated Counseling, LLC

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 or the services requested are not covered by the American Medical Association's CPT guidelines. This means the provider or facility doesn't have an agreement with your plan or that services will not be covered by 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.

Source: <https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf>



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Initial Good Faith Estimate for Health Care Services

Liberated Counseling NPI	1760054522	Stephen Ratcliff NPI	1982933552
Liberated Counseling TIN	871414496	States of Services	Florida, New Mexico, Oregon, & Washington
Service Location	10 Telehealth	Services:	Individual Psychotherapy
Document Date:		Document Expiration:	

Client Information and Good Faith Estimate

DSM 5 Diagnosis	_____		
Client Name	_____	Client Date of Birth	_____
Treatment Duration Estimate:	_____	Session Frequency Estimate:	<u>Every other Week</u>
Estimated Total Sessions:	_____	Total Estimated Cost:	_____

In compliance with section 2799B-6 of the Public Health Service Act, I am providing this estimate of the cost of your therapy services. This Good Faith Estimate shows the costs of items and services that are reasonably expected for your therapy services. The estimate is based on information known at the time it was created.

- This Good Faith Estimate does not obligate or require you to obtain or continue psychotherapy services with me.
- A new Good Faith Estimate may be provided if circumstances change.
- The Good Faith Estimate does not include any emergency or unexpected costs that may arise during treatment. You could be charged more if these circumstances occur.
- The information provided in the Good Faith Estimate is only an estimate, as actual items, services, or charges may differ.
- If there are changes to this estimate, a new estimate will be provided.
- These estimated costs are valid for 12 months from the date of the Good Faith Estimate.
- *Any services not covered by the American Medical Association's CPT Codes and thus not insurance reimbursable are marked in blue.* The fees for services are:

90791 Intake for Individual and family Therapy	\$275 per intake
90837 Individual Therapy and	\$250 per 55-minute hour
99354 Extended Individual Therapy Session	\$250 per 55-minute hour
90839 / 90840 Individual Therapy in a Crisis	\$250 per 60-minute hour
90837 UH Individual Therapy (After Hours)	\$250 per 55-minute hour
90847 / 90846 Family Therapy	\$250 per 55-minute hour
Relationship Therapy	\$175 per 55-minute hour
Relationship Gottman Relationship Checkup Assessment Fee (1x per couple – optional)	\$45 per couple
½ Day Relationship Therapy	\$475
Full Day Relationship Therapy Intensive (6 Hours)	\$925
Legal / Court Involvement if YOU Subpoena Me (This includes preparation and direct involvement time)	\$500 per hour
Late Cancellation / No Show	\$25 per incident
Check or Credit Card Return Fee	\$50 per incident



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Miscellaneous Services YOU request	\$25 per 15 minutes
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- *Please note that this estimate is based upon full-scale cost of services and does not consider sliding scale or other reductions in costs.*

Your Rights

- You have the right to engage in a dispute resolution process if the actual costs of services significantly exceed those listed in the Good Faith Estimate.
- You may contact Liberated Counseling 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 for financial assistance.
- 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.
- While this estimate is not binding, patients may challenge any healthcare bill if the charges substantially exceed the estimated amount. To learn more about disputing a healthcare bill, go to www.cms.gov/nosurprises.

Your signing this form via the attached link attests to your having read, had an opportunity to ask questions about, understood, and agree with the Good Faith Estimate and Surprise Billing Protection Forms.