GOOD FAITH ESTIMATE FOR PSYCHOLOGICAL EVALUATION SERVICES

516 SE Morrison St, Suite 400
Portland, OR 97214
Phone 503-222-0707
Fax 503-764-9646

DATE: [PICK THE DATE]

FACILITY INFORMATION:
MINDSIGHTS, P.C.
NPI: 1124465182
TIN: 46-2761308

FOR:
Client: XXXX
Diagnosis Code(s): TBD after initial consultation
Clinician: TBD at time of scheduling

SERVICE CODE (CPT)	SERVICE DESCRIPTION	HOURS	RATE	AMOUNT
90791	Diagnostic Interviewing/History Gathering/Collateral Info Review/Mental Status Exam/Relevant Documentation	1.5	$285.00	$427.50
96130	Evaluation scope determination; Initial evaluation services	1.0	$285.00	$285.00
96136	Test administration and scoring of administered tests (first 30 min)	0.5	$142.50	$142.50
96137	Test administration and scoring of administered tests (additional 30 min)	5-6	$285.00	$1425-$1710
96131	Additional evaluation services, including interpretation of data, integration of data into written report, written implications and recommendations	5-9	$285.00	$1425-$2565
96131	Interactive debriefing with relevant parties	1-2	$285.00	$285-$570
			ESTIMATED TOTAL COST OF SERVICES	**$3990-$5700**

Expiration Date one year from estimate date.
Using an out-of-network provider, such as MindSights, can cost you more than in-network care.
Please direct questions about this estimate to (503) 222-0707 or office@mindsightspdx.com

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during the psychological evaluation process. You could be charged more if complications or special circumstances occur. If this happens, notice for additional costs will be given and consent for such services will be requested. If charges exceed your estimate, federal law allows you to dispute (appeal) the bill.

If you are billed at least $400 or 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 $400 or more 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, visit www.cms.gov/nosurprises or call 1-877-696-6775.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

For more information about your rights and protections under federal law visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf.

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 agree to receive out-of-network 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 health care provider or patient advocate if you need help knowing if these protections apply to you.

If you use an out-of-network provider, 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** agree to see an out-of-network provider 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 proceed with an out-of-network provider, 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.

► **Review your detailed estimate.** See Good Faith Estimate (above) for a cost estimate for a psychological evaluation.

► **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 MindSights at 503-222-0707, x2305.

► **Questions about your rights?** Contact: The Secretary of State Oregon at 844-469-5512 or at

business.sos@sos.oregon.gov.

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.

By signing the above fee agreement, 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 MindSights and the psychological providers employed by MindSights.

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 prior to signing the above fee agreement 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 received 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. I will still be responsible for payment of services already rendered prior to cancellation.

IMPORTANT: You **don't** have to sign the above fee agreement. But if you don't sign, this provider or facility might not serve you.