

Kyle Hale, CRNP PMHNP-BC
6200 Brooktree Rd Ste 310, Wexford, PA 15090
724-252-4637

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'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 healthcare 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.

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.

See the next page for your cost estimate.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: Kyle Hale, CRNP, PMHNP-BC

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 medication management unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

- ▶ **Review your detailed estimate.** See page four 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 the office of Kyle, CRNP, PMHNP-BC, 724-252-4637
- ▶ **Questions about your rights?** Contact: Pennsylvania Insurance Department, 1-877-881-6388

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.

Out of Network Provider: Kyle Hale, CRNP, PMHNP-BC
6200 Brooktree Rd Ste 310, Wexford PA 15090
724-252-4637
FEDERAL TAX ID: 99-3079126
NPI#:1376218479

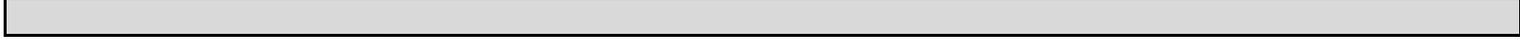
Patient name: _____

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

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	99205	Office/other outpatient visit for evaluation & management of new patient, 45-60 minutes	\$120
	99212	Office/other outpatient visit for evaluation & management of established patient, 10 min	\$20
	99213	Office/other outpatient visit for the evaluation & management of established patient, 15-20 min	\$40
	99214	Office/other outpatient visit for evaluation & management of established patient, 25-30 min	\$60
	99215	Office/other outpatient visit for evaluation & management of established patient, 30-45 min	\$80
	90846	Family Psychotherapy without Patient Present, 26-50 min	\$120/hour
	90833	Additional psychotherapy with patient and/or family member, when performed with evaluation & management service, 16-37 min	\$25
	98966-98968	Telephone Assessment & Management	\$120/hour, prorated
	Cancellation Fee	Your Therapist Requires 24-Business-Hour Cancellation Fee	Full appointment fee
	No Call / No Show Fee	No show without calling in advance	Full appointment fee
	Cancellation with notice	Cancellation of visit via Jituzu message/Phone with more than 24 business hours of notice	No fee
	Production of Records		Prorated based on the amount of time spent at hourly rate (\$120/hr)
	Legal Fees		Prorated based on the amount of time spent at hourly rate (\$120/hr)
	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.
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Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.