WATERSHED
COUNSELING AND CONSULTING

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 isn't in your health plan's network. This means the provider doesn't have an agreement with your plan. **Getting care from this provider could cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills, for example,

- 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 will 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.

Patient name: _____

Out-of-network provider: Kayla Slater, M.A., NCC.

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 three.

- **Review your detailed estimate.** See page three for a cost estimate for each item or service.
- **Call your health plan.** Your plan may have information about how much of these services are reimbursable.
- **Questions about this notice and estimate?** Call Greg Seymour at 423.517.7070
- **Questions about your rights?** Contact: Tennessee Board of Health, Call: 615.741.5735 or email: Unit1HRB.Health@tn.gov

Prior authorization or other care management limitations for In-Network provider services

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, I freely 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:

☐ Kayla Slater, M.A., NCC.

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 will get a bill for the full charges for these items and services.
- I was given a written notice on ____ / ____ / ____ explaining that my provider 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.

- 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 in writing before getting services.

Signature (Patient) (Guardian/authorized representative) _____

Print Name (Patient) (Guardian/authorized representative) _____

Date and time of signature _____

FEDERAL TAX ID: 81-0890981
GROUP NPI#: 1831382356

Patient name: _____

Date of Birth: ____ / ____ / ____

Diagnosis: **Z65.9** Problem related to unspecified psychosocial circumstances
Out-of-network provider name: **Kayla Slater, M.A., NCC.**

The amounts below are 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, subject to change and notification. It doesn't include any information about what your health plan may cover. **Contact your health plan to find out how much, if**
any, your plan will pay.

It is Elbow Tree Group's published policy that we are "Out-of-Network" with all insurance companies and you simply pay the full session fee when you come. If you wish, licensed counselors can provide you with an itemized receipt for services you can use in filing for a possible reimbursement of a portion of your paid fee for service.