Ashley Hoffman, Psy.D., License # 1860
Licensed Psychologist
5151 Research Dr. NW Suite B1 Huntsville, AL 35805

Good Faith Estimate for Health Care Services

Client			
Client Full Name:		Date of Birth:____/___/_____	
Street or PO Box:			
City	State	Zip Code	
Phone			
Primary Diagnosis (if applicable) ___TBD_____ Diagnosis code: _____TBD_____			
Secondary Diagnosis (if applicable) __TBD _____ Diagnosis code: ____TBD _			
Date(s) of Service	Description	Service Code	Estimated amount to be billed
__/ __ /20__	Diagnostic Evaluation	90791	165.00
__/ __ /20__	Individual Psychotherapy for 50 minutes in an outpatient setting	90834	165.00
Total estimate of what you may owe			
Provider signature: *Ashley Hoffman*		Date: January 1, 2022	
NPI (if applicable) 1699022277		EIN: 46-4074138	

Dr. Hoffman does not file insurance and is not in-network for private insurance providers. She cannot determine if or what you will be reimbursed for psychological services. If you plan to file an insurance claim on psychological services, please contact your insurance provider before your first visit to verify your mental health benefits as pre-certification or authorization may be required. You will be provided a complete itemized statement at the time of service that contains all necessary information needed so that you can bill your insurance directly. Please be prepared to pay for your session fee of $165 in full at each appointment. We accept cash, check, or credit card. Cancellations of appointments without a 24-hour notice and no-shows of appointments will be charged the full session rate. Please call the office for additional information.

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Patients may determine frequency and duration in scheduling appointments (as needed) during this time period. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the above client. 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 or items that may arise during treatment. You could be charged more if complications or special circumstances occur. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate

You may contact the health care provider or facility listed 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 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. The initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services furnished. To learn more and get a form to start the process or for questions or more information about your right to a Good Faith Estimate, go to www.cms.gov/nosurprises. 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.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above.

_____ _____

Client Printed/Typed Name Client or Guardian's Signature

Date _____

OMB Control Number: 0938-1401
Expiration Date: xx/xx/xxxx

Disclosure Notice Regarding Patient Protections Against Surprise Billing

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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.

Your Rights and Protections Against Surprise Medical Bills

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 isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what 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're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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 is your 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.

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

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

When balance billing isn't 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 in advance (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 an in-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 services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact an entity responsible for enforcing the federal and/or state balance or surprise billing protection laws.