3069 S. Broad St. #7d - Chattanooga, TN 37408 - or - 1307 Hixson Pk. Chattanooga, TN 37405 - 423.517.7070

Dear Client,

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment. Please sign and date before your next appointment and return the signed document before your next appointment. If you have any questions, please don't hesitate to ask.

Thank you very much,

Elbow Tree Group

ELBOW TREE GROUP
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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

(OMB Control Number: 0938-1401)

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.

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 isyour 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.

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 protection 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:

(1) Greg Seymour, owner of the Elbow Tree Group by calling (423) 517-7070 or emailing greg@elbowtree.com

(2) The Tennessee Board of Health: The Health Care Complaint Portal allows consumers to file a complaint with the appropriate state agency. You will be asked a series of questions to help identify the nature of your complaint. After you have answered all of the questions, you will see a summary page with instructions on how to file your complaint.

Visit https://www.tn.gov/health/health-program-areas/health-professional-boards/report-a-concern.html

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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: _____

Date of Birth: _____ **Diagnosis:** _____

Out-of-network provider: _____

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 below of possible fees.

► **Review your detailed estimate.** See our good faith estimate below 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, Elbow Tree Group Director, 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 the following provider:

□ _____

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.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ | _____

Print name of patient | Print name of guardian/authorized representative

_____ | _____

Date and time of signature | Date and time of signature

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'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.

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3069 Broad Street, Suite 7d Chattanooga, TN 37408
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Table of Services and Fees - Licensed Clinicians

(valid from 7.1.23 until further notice)

CLIENT NAME: _____

Date of Service (If Known)	Service Code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evlauation, 50 minutes	$135.00
	90834	Psychotherapy, 38-52 minutes	$135.00
	90837	Psychotherapy, > 52 minutes (This fee is my hourly rate & is used for all prorated calculations as indicated.)	$2.70 / minute
	90846	Family Psychotherapy without Patient Present, 50 mintues	$135.00
	90847	Family Psychotherapy with Patient Present, 50 mintues	$135.00
	98966-98968	Telephone Assessment & Mgnt.	$2.70 / minute
	98970-98972	Online Digital Evaluation & Mgnt. (Responding to Email & Text Messages)	One (1) email counseling exchange, including one (1) follow-up exchange - $67.50
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Notice	You are Responsible for the Full Fee of the Missed Appointment - $135.00
	Production of Records	Copying, Collating, Notarizing, Mailing	$2.70 / minute
	Legal Engagement Fees	Phone Consults, Letters, Travel Time, Attendance at Court, etc. A minimum prepaid fee of eight (8) hours will be required per day to appear at court.	Prepaid $250.00 / Hour
	Returned Checks		$25.00 / Check
	All card charges	Debit cards, Credit cards, HSA cards used as payment for fees	$5.00 / Transaction / Hour
	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.	

Please note that **Place of Service** (in office vs. tele-mental health) is not delineated above since the charges are identical.

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Table of Services and Fees - Pre Licensed Clinicians

(valid from 7.1.23 until further notice)

CLIENT NAME: _____

Date of Service (If Known)	Service Code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evlauation, 50 minutes	$110.00
	90834	Psychotherapy, 38-52 minutes	$110.00
	90837	Psychotherapy, > 52 minutes (This fee is my hourly rate & is used for all prorated calculations as indicated.)	$2.20 / minute
	90846	Family Psychotherapy without Patient Present, 50 mintues	$110.00
	90847	Family Psychotherapy with Patient Present, 50 mintues	$110.00
	98966-98968	Telephone Assessment & Mgnt.	$2.20 / minute
	98970-98972	Online Digital Evaluation & Mgnt. (Responding to Email & Text Messages)	One (1) email counseling exchange, including one (1) follow-up exchange - $55
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Notice	You are Responsible for the Full Fee of the Missed Appointment - $110
	Production of Records	Copying, Collating, Notarizing, Mailing	$2.20 / minute
	Legal Engagement Fees	Phone Consults, Letters, Travel Time, Attendance at Court, etc. A minimum prepaid fee of eight (8) hours will be required per day to appear at court.	Prepaid $250.00 / Hour
	Returned Checks		$25.00 / Check
	All card charges	Debit cards, Credit cards, HSA cards used as payment for fees	$3.00 / Transaction / Hour
	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.	

Please note that **Place of Service** (in office vs. tele-mental health) is not delineated above since the charges are identical.

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Table of Services and Fees - Graduate Interns

(valid from 7.1.23 until further notice)

CLIENT NAME: _____

Date of Service (If Known)	Service Code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evlauation, 50 minutes	$60 ($35 for college students)
	90834	Psychotherapy, 38-52 minutes	$60 ($35 for college students)
	90837	Psychotherapy, > 52 minutes (This fee is my hourly rate & is used for all prorated calculations as indicated.)	$1.20 / minute ($.70 /minute for college students)
	90846	Family Psychotherapy without Patient Present, 50 mintues	$60 ($35 for college students)
	90847	Family Psychotherapy with Patient Present, 50 mintues	$60 ($35 for college students)
	98966-98968	Telephone Assessment & Mgnt.	$1.20 / minute ($.70 /minute for college students)
	98970-98972	Online Digital Evaluation & Mgnt. (Responding to Email & Text Messages)	One (1) email counseling exchange, including one (1) follow-up exchange - $35
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Notice	You are Responsible for the Full Fee of the Missed Appointment - $60 / $35
	Production of Records	Copying, Collating, Notarizing, Mailing	$1.20 / minute ($.70 /minute for college students)
	Legal Engagement Fees	Phone Consults, Letters, Travel Time, Attendance at Court, etc.	As a Graduate Intern, I am not permitted by my graduate program to engage in these.
	Returned Checks		$25.00 / Check
	All card charges	Debit cards, Credit cards, HSA cards used as payment for fees	$5.00 / Transaction / Hour
	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.	

Please note that **Place of Service** (in office vs. tele-mental health) is not delineated above since the charges are identical.

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Table of Services and Fees - Neurofeedback

(valid from 7.1.23 until further notice)

CLIENT NAME: _____

Date of Service (If Known)	Service Code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90901	Biofeedback Session - by any modality	$175 / session
		qEEG Brain Mapping Session	$175 / session
		Pre-training Report of Findings (ROF)	$175 / session
		Post-training Report of Findings (ROF)	$175 / session
		Level 1 Bundle @ 20% Discount	$3,500 / total
		Level 2 Bundle @ 30%. Discount	$3,150 / total
		Level 3 Bundle @ 40% Discount	$2,800 / total
		Level 4 Bundle @ 50% Discount	$2,450 / total
	98966-98968	Telephone Assessment & Mgnt.	$2.70 / minute
	Production of Records	Copying, Collating, Notarizing, Mailing	$2.70 / minute
	Legal Engagement Fees	Phone Consults, Letters, Travel Time, Attendance at Court, etc.	Prepaid $250.00 / Hour
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Notice	You are Responsible for 50% of Fee of the Missed Appointment - $87.50
	Returned Checks		$25.00 / Check
	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.	

Please note that **Place of Service** (in office vs. tele-mental health) is not delineated above since the charges are identical.