from fear and frustration *to fulfilling relationships*
JEANETTE RAYMOND, Ph.D.

12304 Santa Monica Blvd. #215. Los Angeles, CA 90025

Phone: 310.985.2491
Email: losangeleswestsidetherapy@protonmail.com

2023

Dear ,

In compliance with the No Surprises Act that goes 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,

Jeanette Raymond, Ph.D.
License # PSY 21419

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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 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 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.

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 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: Jeanette Raymond, Ph.D.

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 therapy 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 310.985.2491

► **Questions about your rights?** Contact: Board of Psychology, Consumer Dept. 1625 North Market Blvd., Suite N-215, Sacramento, CA 95834. Phone: 866. 403.322. Email: bopmail@dca.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.]

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.

By signing, 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 (select all that apply):

☐ Jeanette Raymond, Ph.D.

11911 San Vicente Blvd. Suite 270, Los Angeles CA 90049

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced nor 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 on January 1st, 2022 explaining that my provider or facility is not 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 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 or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility may not treat you.

Patient's signature	patient's signature
Print name of patient	Print name of patient
Date and time of signature	Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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FEDERAL TAX ID: 20-580 4851

More details about your estimate

Patient name: _____

Diagnosis: **z65.9 unspecified psychosocial concerns**

Out-of-network provider: Jeanette Raymond, Ph.D.

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

Client Name: _____

Date of Service	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90834	Psychotherapy, 38-52 minutes (This fee is my session rate for 50 minutes)	$250
	90837	Psychotherapy ≥ 53 minutes	$250
	90839	Psychotherapy for a Crisis (30-74 minutes)	$300
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$300
	90846	Family Psychotherapy without Patient Present, 50 minutes	$250
			$250
	90847	Family Psychotherapy with Patient Present, 50 minutes, including telehealth	$250
	90847	Couples Psychotherapy with Patients Present, 50 minutes	$250
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	$350
	Cancelation Fee	Your Therapist Requires a 48-Hour Cancelation Fee	$250
	Production of Records		$250
	Legal Fees		$450
	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 presenting clinical concerns.	

Please note that Place of Service (in office vs. telemental health) i not delineated above since the charges are identical.