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**CHILD PSYCHOLOGY MARIN**

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The No Surprises Act Standard Notice And Consent Documents

(OMB Control Number: 0938-1401)

# No 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 bypass use of your in-network insurance benefits and the protections they provide, and possibly pay more for out-of-network care.

You’re getting this notice because I am not in your health plan’s network. This means I do not have an agreement with your plan.

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.

If you sign this form:

* You may be giving up the protections that come with using your insurance coverage.
* You will owe the full costs billed for items and services received.
* Your health plan might not count the amount you pay towards your deductible and out- of-pocket limit. Every health policy is different so please contact your health plan for more information.

If you didn’t have a choice of providers when receiving care, you should not sign this form.

* For example, in the case where a doctor was assigned to you with no opportunity to choose a different provider.

If you would like, 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 a single case agreement with out-of-network provider. You should know however, that I do not participate in single case agreements.

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. Contact your health plan to determine if prior authorization is required, and what information is needed to get coverage.

# Estimate of what you could pay

**Patient name: Out-of-network provider’s name:** Julie Maccarin, Ph.D., OT/L

**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 court ordered mandatory treatment. Please see the breakdown of possible fees below.

* **Review your detailed estimate.** See the 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?** Contact me either by email or phone, or contact your insurance provider.
* 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 & )** |
|  | 90791 | Initial Diagnostic Evaluation | $350.00 |
|  | 90834 | Psychotherapy, 45 minutes | $250.00 |
|  | 90846 | Family Psychotherapy without Patient Present, 60 minutes | $325.00 |
|  | 90847 | Family Psychotherapy with Patient Present, 45 minutes/60 minutes | $250.00/$325.00 |
|  | 98966-98968 | Telephone Consultations/Meetings with Other Professionals on Your Behalf | Prorated based on the amount of time spent at hourly rate |
|  |  | Cancellation Fee  48-Hour Cancellation Notice Required | Without 48- hour notice, you are responsible for the fee for the missed appointment |
|  |  | Production of Records | Prorated based on the amount of time spent at hourly rate |
|  |  | Consult with Attorneys/ Legal Matters | $500.00 per hour or any part thereof |
|  |  | High Conflict Divorce | There is a $40 per session surcharge in cases of high conflict divorce. |
|  | | | |
|  | Total Estimate: | This Good Faith Estimate explains my rate for each service provided. I will collaborate with you throughout your treatment to determine how many sessions and/or services you or your child may need to receive the greatest benefit based on diagnosis(es) and presenting clinical concerns. | |
|  | | | |

* Please note that Place of Service (in office vs. teletherapy) is not delineated above since the charges are the same.

**Prior authorization or other 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 for coverage of service before you get it. If prior authorization is required, contact your health plan to determine what information is needed to get coverage.

**More information about your rights and protections:**

For more information about your rights under Federal law 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 California state law. visit <https://californiahia.org/consumer-patient-rights>

I acknowledge that I am signing this document of my own free will and am not being coerced or pressured. I also understand that:

* I am agreeing to receive services for myself/my family/my child from Julie Maccarin, Ph.D, OT/L, of Child Psychology Marin.
* I may be 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 costs under my health plan.
* I was given a written notice on 1/1/22 explaining that my provider is not in my health plan’s network. This notice includes 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. (Please advise me if you would like a paper copy of this document).
* I fully and completely understand that some or all amount I pay might not count toward my health plan’s deductible or out-of-pocket limit.
* I can end this agreement by notifying Julie Maccarin in writing.

Please note**:** You don’thave to sign this form. But if you don’t sign it, I may not be able to provide services to you or your child.

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

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

It contains important information about your rights and protections