BELLA VITA
INTEGRATED HEALING

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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: **Bella Vita Integrated Healing**

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 treatment 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 Elizabeth Shrader, Owner of Bella Vita Integrated Healing ~ 602-671-3091~E_ShraderDNP@protonmail.com

Questions about your rights? Contact:
The Office of the Secretary of State
1700 W Washington St Fl 7
Phoenix AZ 85007-2808
602-542-4285

- The U.S. Centers for Medicare & Medicaid Services (CMS) at **1-800-MEDICARE** (1-800-633-4227) or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.
- If you believe you've been wrongly billed, contact the Arizona Department of Insurance and Financial Institutions at 1 (602) 364-3100.
- Visit for "Surprise Out-of-network Bill Dispute Resolution" for more information about your rights under Arizona 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 Federal law.

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):

☐ Elizabeth Shrader, DNP, MSN, PMHNP-BC, WHNP-BC

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 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 [enter date of notice] explaining that my provider or facility 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 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 myhealth 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 might not treat you.

_____	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.

FEDERAL TAX ID: 92-1682054

More details about your estimate

Patient name: _____

Date of Birth: _____

Diagnosis: To be determined by your provider. If you need this information, please do not hesitate to ask.

Out-of-network provider(s) or facility name: Bella Vita Integrated Healing/Elizabeth A Shrader, PLLC

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 (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90792	Initial Psychiatric Diagnostic/Complex Evaluation 90 min	$400
	90792	Ketamine Evaluation 90-Min	$400
	90792	Initial Psychiatric Diagnostic/Ketamine Evaluation 60 min	$300
	90792	Ketamine Evaluation 60-Min	$300
	99214	Medication Management, Level 4 Moderate Complexity 45 min	$225
	99213	Medication Management, Level 3 Low Complexity 30 min	$150
	99080	Medical Clearance/FMLA Forms (fee is per encounter/form)	$50
	96132	Neuropsychological Testing (QB Test for ADHD)	$200 per test
	Multiple	**Pharmacogenomic Testing:**	This service is provided by an outside vendor. Therefore, it is the patient's responsibility to determine insurance coverage and/or all out of pocket costs associated with this testing.
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records		Prorated based on the amount of time spent at hourly rate
	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 concens	

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

Patient Name Patient or Guardian Signature Date