Allison C. Gary, MA, LPC, NCC
AllisonCGary@gmail.com
Direct: 720-619-1058
300 S. Jackson St, suite 200
Denver, CO 80209

ACG Counseling Services LLC

The No Surprises Act Standard Notice and Consent

The No Surprises Act was issued into law starting January 1, 2022. It has already been revised several times, so it is subject to change. I will do my best to keep you up to date as much as possible with any changes that may impact you or your care.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. This Act is to help protect patients financially from "surprise billing" or "balance billing." When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as copayments, coinsurance 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. 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.

Definitions:

Balance Billing – When an "out-of-network" provider bills you for the difference between what your plan agreed to pay and the full amount charged for services. 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 – An unexpected 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.

Allison Gary, LPC/ACG Counseling Services is an "out-of-network" provider, and not in-network/contracted with any insurance companies – also called "private pay." Getting care from Allison Gary, LPC could cost you more than finding an in-network provider. Ask your health care provider or patient advocate about protections that apply to you and for information about in-network providers.

In signing 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.

If you intend to submit a Third-Party Claim for reimbursement with your insurance company, please discuss this with me for appropriate paperwork to be provided.

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 another one. You are 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.

For more information about your rights under Federal law, visit: https://www.cms.gov/nosurprises. For more information about Colorado State law, visit: https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-health-care

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Good Faith Estimate:

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate for expected charges for items and services to individuals who are not enrolled in an insurance plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services. A Good Faith Estimate must be provided within 3 business days upon request or at least within 1 business day of scheduling a service.

The Good Faith Estimate will include estimated fees for the calendar year. In the event of updates to fees, ample notice will be provided and an oral discussion will be held prior to charges. An updated Good Faith Estimate will be provided in the event of fee changes, and/or at the beginning of a new calendar year.

By signing below, I understand the above information and give up my federal consumer protections and agree that I might pay more for out-of-network care. I am agreeing to enter into services with Allison Gary, LPC of ACG Counseling Services, contractor to Ipseity Counseling Clinic. I agree to be responsible for all costs associated with my care. I affirm to receipt of a Good Faith Estimate explaining estimated costs, and fully and completely understand that some or all amounts I pay might not count toward my health plan deductible or out-of-pocket limit.

_____ 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

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Good Faith Estimate

Client Name:_____ Date of Birth:_____

Disclaimer: *This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for services. 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 that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, or if you are billed more than this Good Faith Estimate, federal law allows you to dispute (appeal) the bill.*

- Initial Phone Consultation: Free Date:
- Initial Intake Appointment: $ Date:
- Standard Session Fee: $
- Estimated Cost for Weekly Appointments: $ (service start date through 12/31/2022)
- Estimated Cost for Bi-Weekly Appointments: $ (service start date through 12/31/2022)
- Estimated Cost for Monthly Appointments: $ (service start date through 12/31/2022)
- 90-minute Session Fee: $ /per 90-minute session
- EMDR Session Fee: *if EMDR is added to your care, a new Good Faith Estimate will be provided.*
- Telephone Fee: Prorated based on the amount of time spent at hourly rate (first 10 minutes are free of charge)
- Cancelation Fee: You are responsible for the fee of the appointment missed
- Production of Records Fee: Prorated based on the amount of time spent at hourly rate with a minimum of 15 minutes
- Administrative Fee for additional paperwork: Prorated based on the amount of time spent at hourly rate with a minimum of 15 minutes

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

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In the event that additional services may be required for your care, and adjusted updated Good Faith Estimate will be provided.

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.

The amount above 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.

Your signature below indicates that your provider has gone over this Good Faith Estimate with you any questions or concerns have been addressed. Thank 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