dr. carrie poline
Child, Adolescent & Adult Psychiatry
Double Board Certified

Surprise Billing Protection Form
Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

The following information is being presented to you due to the new federal law called the "No Surprises Act" which went into effect 1/1/2022. This law requires us to provide you with a "good faith estimate" of the **total cost** of your treatment. Estimating the total cost of psychiatric and psychotherapy treatment is very difficult because the course of treatment varies for everyone. The law requires us to make this estimate prior to completing an assessment which further complicates things. In psychiatry and psychotherapy, there are only a handful of CPT codes (billing codes) that can be used and the prices for those codes do not vary. Attached you will find a good faith estimate of your treatment.

You have a right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

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.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs, like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

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 are not 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. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this physician isn't in your health plan's network. This means the physician and the facility doesn't have an agreement with your plan. **Getting care from this physician/facility could cost you more.** Ask your health care provider 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 out-of-pocket limit. Contact your health plan for more information.

Carrie Poline, D.O., FAPA • drcarriepoline.com
Office: 404-220-8022 Fax: 404-795-5762 • 6100 Lake Forrest Drive, Suite 330, Atlanta, GA 30328

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 physician or another one. See below for your cost estimate.

By signing, I give up my federal consumer protections and agree to pay more of out-of-network care. With my signature, I am saying that I agree to get the items or services from:

Carrie Poline, D.O., FAPA, CEDS

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, or have to pay out-of-network.
- I was given a written 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 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 might not treat you. You can choose to get care from a provider or facility in your health plan's network.**

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 for out-of-network providers. This means that **the final cost of services may be different than this estimate.** You and your psychiatrist will determine the frequency of appointments together based on your needs. This may vary depending on whether you receive services for medication management, therapy, or both. We are concerned that there will be an element of "sticker shock." Seeing the total cost of a year's work of treatment can be alarming, but there is no guarantee that you will be in treatment for a full year. **Please keep in mind that this estimate does NOT account for any potential out-of-network reimbursement from your insurance carrier**.

Please be aware of the following maximum out-of-pocket scenarios:

1. **Medication management**: typically requires an initial 90-minute appointment ($500) or 60 minutes eval for adults ($350), plus up to monthly 30-minute appointments at $185 each or 60 minute appointments at $300 each.

2. **Therapy:** typically requires an initial 90-minute appointment ($500 for a 90-minute eval, $350 for 60 minute eval for an adult), plus up to weekly or monthly 50 minute appointments at $275 each.

3. Both therapy and medication management: this would follow the "therapy" model above (#2).

You should also be aware that, since we charge for "other professional services" (described in the new client contract), this may add additional out-of-pocket costs. While it is impossible to predict the exact number of professional services a patient may need outside of their appointments, you should be aware of the hypothetical estimation of 30 minutes per year, which would add an additional or a 12-month total of $185.

CONSENT OF GOOD FAITH ESTIMATE:

Patient		
Patient First Name	Middle Name	Last Name
Patient DOB:		
Patient Mailing Address, Phone #, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] Phone [ ] Mail [ ] Email		
Patient Diagnosis *we are unable to diagnose without an assessment		
Primary Service or Item [ ] Requested [X] Scheduled		
Patient Primary Diagnosis		Primary Diagnosis Code
Encounter for screening examination for other mental health and behavioral disorders.		**Z13.39**
If scheduled, list the date(s) the Primary Service or Item will be provided: **Sessions are weekly unless otherwise noted.** [ ] Check this box if the service or item is not yet scheduled		
Date of Good Faith Estimate:		

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

The following are our fees for services, you estimate is being based on the fact that you are scheduled to see a Psychiatrist (D.O.)

	60 min Intake (ADULT) 99205	90 min Intake 99205	50 min Session 99214+ 90836	60 min Extended Session 99212-99214	30 min Session 99212-99214	Complex Forms and Letters
PSYCHIATRIST (D.O.)	$**350**	$**500**	$**275**	$**300**	$**185**	$**100**

Carrie Poline, D.O., FAPA, CEDS
NPI:1699988061 Tax ID# 27-3243110

Disclaimer: This Good Faith Estimate shows the costs of the items and services that are reasonably expected to be for your health care needs for an item or service. 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. Federal law allows you to dispute (appeal) the bill if this happens. If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.

You may also start a dispute resolution process with the US Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the Agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process go to www.cms.gov/nosurprises
For questions or information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Name: _____

Signature (Parent if a minor): _____ Date: _____