Nina Nguyen, Ph.D.

Clinical Psychologist | PSY 30775

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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.

You're getting this notice because Nina Nguyen, Ph.D. isn't in your health plan's network and doesn't have an agreement with your plan. Getting treatment from Nina Nguyen, Ph.D. 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 innetwork provider or facility.

Estimate of what you could pay

Patient name: _____

Date of Birth: _____

Out-of-network provider(s) or facility name: Nina Nguyen, Ph.D., A Psychological Corporation

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 the following page 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? Questions about your rights?** Contact the California Secretary of State, Dr. Shirley N. Weber, (916) 653-6814

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-againstsurprise-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-ofnetwork care. With my signature, I am agreeing to get the items or services from Nina Nguyen, Ph.D. I acknowledge that I am consenting to treatment of my own free will and 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-ofnetwork cost-sharing under my health plan.
- 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.

ACKNOWLEDGING SIGNATURES

I have read and understood the Informed Consent for the No Surprises Act.

Patient's Name (print)	Signature	Date
Nina Nguyen, Ph.D.		
Clinical Psychologist	Signature	Date

Nina Nguyen, Ph.D.

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GOOD FAITH ESTIMATE

Patient name: _____

Date of Birth: _____

Diagnosis: To be determined

Out-of-network provider(s) or facility name: Nina Nguyen, Ph.D., A Psychological Corporation

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

Patient name:_____

Service code (CPT Code)	Description	Fee for Service
Diagnostic and Psychotherapy Codes		
90791	Initial Diagnostic Evaluation	$250
90832	Psychotherapy, 16-37 minutes	$175
90834	Psychotherapy, 38-52 minutes	$200
90837	Psychotherapy, 53-89 minutes	$300
90839	Psychotherapy for a Crisis (30-74 minutes)	$250
+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$85
90846	Family/Couples Therapy, w/o Patient, 26-74 minutes	$250
90847	Family/Couples Therapy, w/Patient, 26-74 minutes	$250
Miscellaneous Services		
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
Cancellation Fee	Your Therapist Requires a 24-Hour Cancellation Fee	$250
Production of Records	Record review and preparation	$200
Legal Fees	Court appearance, Preparation	$350
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 clinical concerns.	

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

ACKNOWLEDGING SIGNATURES

I have read and understood the Informed Consent for the Good Faith Estimate.

_____

Patient's Name (print) Signature Date

Nina Nguyen, Ph.D.

Clinical Psychologist Signature Date