Khristina Williams LMHC, LCP, PLLC
750 Officers Row Vancouver, WA 98661
www.williamscounselinglmhc.com 360-771-2258

January 1, 2022

Dear Client,

In compliance with the No Surprises Act that went into effect on January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing."

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (attached). It is difficult to determine the true length of treatment for mental health care, each client has a right to decide how long they would like to participate in mental health care. Therefore, attached you will find a fee schedule for the services typically offered by your therapist, and we will collaborate together every 90 days to determine how many sessions you may need.

It is a Federal requirement that we have each client sign this form to begin/resume treatment. Please sign and date before your next appointment so that this document can be in your file. If you have any questions, please do not hesitate to ask.

Warmly,

Khristina Williams, LMHC, LPC
Licensed Mental Health Counselor

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THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1404)

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 are not required to sign this form and should not sign it if you did not have a choice of a health care provider when you received care. You can choose to get care from a provider in your health plan's network, which may cost you less.

You're getting this notice because this provider is not in your health plan's network. This means the provider does not have an agreement with your plan.

Getting care from this provider 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 should not sign this form if you did not 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.

Estimate of what you could pay

Client Name: _____

Out-of-network provider(s) or facility name: Khristina Williams LMHC, LPC, PLLC

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 seven.

- **Review your detailed estimate**. See page seven for a cost estimate for each item or service.
- **Call your health plan**. Your health plan may have better information about how much of these services are reimbursable.
- **Questions about this notice and estimate?** Call Khristina at 360-771-2258.
- **Questions about your rights?** Contact: Washington Department of Health 360-236-4700, Fax number 360-236-4818, Email address: hsqa.csc@doh.wa.gov

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):

- Khristina Williams LMHC, LPC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressure. 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 must pay out-of-network cost-sharing under my health plan.
- I was given a written notice as of January 1, 2022 explaining that my provider is not 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.
- 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 in writing before getting services.

IMPORTANT: You do not have to sign this form. But if you do not sign, this provider may not be able to treat you.

_____ _____

Patient's signature Printed name of patient

_____ _____

Guardian/authorized representative signature Printed name of guardian/rep.

_____

Date and time or signature

Take a picture and /or keep a copy of this form. It contains important information about your rights and protections.

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FEDERAL TAX ID: 45-5254638

More details about your estimate

Client Name: _____

Date of Birth: _____

Diagnosis: A diagnosis is not mandatory for private pay therapy but can be provided to you upon request. A discussion about your diagnosis with your clinician will help to decide whether an official diagnosis will be beneficial to your mental health care.

Out-of-network provider(s) or facility name: Khristina Williams, LMHC, LPC

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 does not 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: _____

Service Code	Description	2022 Fee for Service
90834	Psychotherapy, 38-52 minutes	$ 135
90837	Psychotherapy, 53-60 minutes	$135
90847	Family Psychotherapy with Patient Present, 50 minutes	$150
90791	Initial assessment	$150
Cancellation fee	Your therapist requires a 24-hour cancellation fee	$135
Production of records		$160
Legal Fees		$500 per hour

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. Clients of Khristina Williams, LMHC, can expect to see their therapist in weekly 50-minute therapy sessions for 40-50 weeks per calendar year unless otherwise agreed upon. Most clients in therapy will be in weekly or bi-monthly therapy sessions for 1-2 years before reevaluating progress and need for continued care. It is not uncommon to stay in therapy for many years depending on the depth of the collaborative work. At any time, you are free to stop therapy or reduce sessions with no consequence from your provider although a late cancellation charge will be added to your fee for services if you do not provide a minimum 24 hours notice of cancellation.