Heather Luevano MFT

Coastal Family Therapy

License #MFC42278

P.O Box 2284 Carlsbad, CA 92018

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GOOD FAITH ESTIMATE OF EXPECTED CHARGES

If you do not have insurance or are not using your insurance to pay for your services (you are paying out-of-pocket), you have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.

Under the law, health care providers must give patients who don't have insurance or who are not using their insurance (paying out-of-pocket for services) an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

SURPRISE BILLING PROTECTION FORM, Section 2799B-6

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you knowingly give up those protections and possibly pay more for out of network care.

IMPORTANT: You are not required to sign this form and should not 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 be of less cost to you.

If you would 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.

Name:_____ Cash Rate:_____

You are receiving this notice because this provider is not in your health network plan. This mean the provider does not have an agreement with your insurance plan.

By signing, I agree to give up my federal consumer protections and agree to possibly pay more for out-of-network care.

With my signature, I am saying that I agree to the cash rate of the services from:

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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 am 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 verbally given this notice on_____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 received the notice on paper or electronically, consistent with my choice.

I fully and completely understand that some or all amounts I pay might not count towards my health plan's deductible or out-of-pocket limit.

I can end this agreement by notifying the provider in writing if I do not wish to continue services.

IMPORTANT: You do not have to sign this form. But by not signing, this provider may not treat you or provide a service. You can choose to get care from a provider or facility in your health plan's network.

Printed Patients Name:_____

Patients Signature: _____ Date: _____

OR

Guardian/authorized representative's Printed Name: _____

Guardian/authorized representative's Signature: _____

Providers Signature:_____ Date:_____