Jeff Levy, LCSW
Psychotherapist, Consultant, Trainer
NPI: 1720118441
EIN: 83-2695153

Well, if you want to sing out, sing out.
And if you want to be free, be free.
'Cause there's a million things to be
You know that there are.
---Cat Stevens

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 receive out-of-network services that may result in you paying more for services thereby giving up those protections.

> **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.*
>
> *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 provider isn't in your health plan's network. This means the provider doesn't have an agreement with your plan.

Getting Care From This Provider Could Cost You More

If your plan covers the service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities
- 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 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 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.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

Your cost estimate is included on the following pages.

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ESTIMATE OF WHAT YOU COULD PAY

Client name: _____

Out-of-network provider: Jeffrey Levy, LCSW, 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 consider the following:

- **Review your detailed estimate.** See cost estimate for each service.
- **Call your health plan.** For information about how much of these services are reimbursable.
- **Prior authorization or other care management limitations** Except in an emergency, your health plan may require prior authorization (or other limitations) for certain services. This means you may need your plan's approval that it will cover a service before treatment. If prior authorization is required, ask your health plan about information is necessary to get coverage
- **Questions about your rights?** Contact Illinois Department of Financial and Professional Regulation
- **Questions about this notice and estimate?** Call Jeff at 773.490.2772

With my signature, I agree to receive services from Jeffrey Levy, LCSW. I also acknowledge that I am consenting of my own free will and am not being coerced or pressured. I understand that:

- I was given a written notice on _____explaining that my provider isn't in my health plan's network, an estimated cost of services, and what I may owe if I am treated by this provider.
- I got the notice either on paper or electronically, consistent with my choice.
- I'm giving up some consumer billing protections under Federal law.
- I may get a bill for the full charges for these services or have to pay out-of-network cost-sharing under my health plan.
- 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.

Client Signature	or Guardian/authorized representative's signature
Print name of client	or Print name of guardian/authorized representative
Date and Time of Signature	or Date and Time of 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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MORE DETAILS ABOUT YOUR ESTIMATE

Client Name _____ **DOB** _____ **Diagnosis** _____

Out-of-Network Provider: Jeffrey Levy, LCSW

The amount below is an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the 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**.

Consult your health plan for how much your plan may pay and how much you may have to pay.

GOOD FAITH ESTIMATE
Table of Services and Fees

Date of Service	Service code (CPT Code)	Description	Fee for Service
	90791	Initial Diagnostic Evaluation	$
	90832	Psychotherapy, 16-37 minutes	$
	90834	Psychotherapy, 38-52 minutes	$
	90837	Psychotherapy ≥ 53 minutes*	$
		**This fee is my hourly rate, used for all prorated calculations*	
	90847	Family Psychotherapy with Client Present, 50 minutes	$
	90853	Group Psychotherapy	$
	98966-98968	Telephone Assessment & Management	Prorated at hourly rate, based on the amount of time spent
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated at hourly rate, based on the amount of time spent
	Cancelation Fee	Your Therapist Requires a 48-Hour Notice to Cancel	You are Responsible for Missed Appointment Fee
	Legal Fees	This fee is my hourly rate & used for all prorated calculations as indicated	$250
	Total Estimate:	This Good Faith Estimate explains Jeff's rate for each service provided. Jeff will collaborate with you throughout your treatment to determine how many sessions will best help you achieve your goals.	

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