Orchard Human Services, Inc.
Dr. Darleen Claire Wodzenski, MS ESE, MA CMHC, QPPE, PhD, LPC, NCC
4813 Ridge Road Suite 111-83 Douglasville GA 30134 (770) 686-0894 Office (877) 660-8884 Fax
OrchardHumanServices.org - Website Appointments@OrchardHumanServices.org - Email

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

NOTICE: Orchard Human Services, Inc. and/or Dr. Darleen Claire Wodzenski, PhD, LPC, NCC do participate in many insurance networks and plans including Amerigroup, AETNA, Anthem, Beacon, Blue Cross/Blue Shield, Caresource, GEHA, Optum, Cigna, Evernorth, United Healthcare and others. Please verify participation with your insurance plan prior to commencing care. Let us know if you need help contacting your insurance company.

According to governmental mandate, we must provide you with this form and related information; if you have questions, feel free to ask us. We know this is confusing and are happy to go over this form and any questions you may have. Please contact (770) 686-0894 or Forms@OrchardHumanServices.org

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.

If you'd 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.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility 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 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:

Patient name:

Out-of-network provider(s) or facility name: Orchard Human Services, Inc. and/or Dr. Darleen Claire Wodzenski, MS ESE, MA CMHC, QPPE, PhD, LPC, NCC

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 page four 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?** Call (770) 686-0894 or email forms@orchardhumanservices.org

► **Questions about your rights?** Call (770) 686-0894 or email forms@orchardhumanservices.org

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 acknowledge 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):

☐ Dr. Darleen Claire Wodzenski, MS ESE, MA CMHC, PhD, LPC, NCC & Staff

☐ Orchard Human Services, Inc. & Staff

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 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 given a written notice on _____[DATE] 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 myhealth 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 nottreat you.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | 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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Orchard Human Services, Inc. Group NPI #1609428689 Federal Tax ID 35-2471025

More details about your estimate

Patient name: _____

Date of Birth: _____

Diagnosis: ☐ _____

☐ **Z65.9** Problem related to unspecified psychosocial circumstances

Out-of-network provider(s) or facility name: Orchard Human Services, Inc. and/or

Dr. Darleen Claire Wodzenski, MS ESE, MA CMHC, PhD, LPC, NCC, ACS
Beth Wodzenski, MA CMHC, NCC, Master's Level Counselor

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

Client Name: _____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$200
	90832	Psychotherapy, 16-37 minutes	$125
	90834	Psychotherapy, 38-52 minutes	$150
	90837	Psychotherapy ≥ 53 minutes [This fee is the hourly rate that is also used for all prorated calculations]	$175
	90853	Group Psychotherapy	$75
	98966-98968	Telephone Assessment & Management	Prorated based on 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
	Late Cancelation Fee	We Require 24-Hour Notice for Cancelation	You are Responsible for Fee of Missed Appointment
	99446	Interprofessional Consultation 5-10 minutes of medical consultative discussion and review	$75
	99447	Interprofessional Consultation 11-20 minutes	$100
	99448	Interprofessional Consultation 21-30 minutes	$160
	99449	Interprofessional Consultation ≥ 31 minutes	$200
	Production of Records	Our costs for reproducing, accessing, and delivering paper or electronic forms.	$.50 Per Page
	Court & Legal Fees	Hourly cost of records review, research, preparation, and testimony	$500
	Intern/Practicum Sessions	Counseling, therapy, and intervention services delivered by an Internship or Practicum provider - fee per session	$25-$60
	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 v. Telemental Health] is not delineated above as charges are same.			

END OF DOCUMENT