THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
HEALTH SCIENCES

DEPARTMENT OF PSYCHOLOGY
Chafee Hall, 142 Flagg Road, Kingston, RI 02881 USA p: 401.874.2193 f: 401.874.2157 web.uri.edu/psychology

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENT
(WITH GOOD FAITH ESTIMATE)
(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 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.

See the next page for your cost estimate.

Provider(s) or facility name: Psychological Consultation Center, University of Rhode Island

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?** Please speak with your provider, or contact:
  The Psychological Consultation Center
  Chafee Social Sciences Building, Suite 100
  142 Flagg Rd.
  Kingston, RI 02881
  401-874-4263
  uripcc@etal.uri.edu
- **Questions about your rights?** contact:
  The Rhode Island Department of Health
  3 Capitol Hill
  Providence, RI 02908-5097
  www.health.ri.gov
  401-222-5960

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.

If I choose to initiate treatment at the Psychological Consultation Center, I will be asked to sign a document confirming that I have read this information regarding the No Surprises Act. By signing that document, I understand that 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 The Psychological Consultation Center, University of Rhode Island and acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- 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 explaining that the PCC isn't in my health plan's network, the estimated cost of services, and what I may owe for services at the PCC.
- 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.

Psychological Consultation Center

Chafee Social Sciences Building, Suite 100
142 Flagg Rd
Kingston, RI 02881
401-874-4263
uripcc@etal.uri.edu
https://web.uri.edu/pcc/

University of Rhode Island FEDERAL TAX ID: 223011455

Diagnosis: Z65.9 Problem related to unspecified psychosocial circumstances

- *Specific diagnoses to be refined at the initiation of care*

Out-of-network provider(s) or facility name: Psychological Consultation Center

The amount below is only an estimate; it isn't an offer or contract for services. The estimate shows the estimated costs of weekly treatment over a 1 year duration. This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. It doesn't include any information about costs beyond one year nor 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.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. **If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call the Psychological Consultation Center at 401-874-4263.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Service code	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
Intake Evaluation	Intake Evaluation	$30
Adult Psychotherapy	Session Fee Cancellation Fee Good Faith Estimate based on a 1 year course of treatment. Your provider will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your presenting clinical concerns.	$20 $20 $990
Child Anxiety Program (CAP)	Session Fee Cancellation Fee Good Faith Estimate based on a 20-week course of treatment. Your provider will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your presenting clinical concerns.	$55 $55 $1130
Assessment Services	Testing Session(s) – covers the cost of all testing appointments. Feedback Session Good Faith Estimate for Assessment Services. Your provider will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your presenting clinical concerns.	$365 $200 $595

Please note that charges are identical for services provided in-person vs. telehealth.