THE
mending
SPACE

Dear Client,

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

This act requires that The Mending Space notify you of your federally protected rights to be informed when services are rendered by an out-of-network provider, if you are uninsured, or if you elect to not use your insurance when seeking services.

Additionally, we are required to provide you with a Good Faith Estimate (GFE) of the cost of services. While it is difficult to determine the true length of treatment for mental healthcare due to a variety of factors, you have a right to decide how long you would like to participate in mental healthcare. Attached is a fee schedule for the services typically offered by your therapist, and we will collaborate with you on a regular basis to make sure we are on the same page about the continued length of your treatment.

It is a requirement that each client sign this form to show your understanding of your rights under the No Surprises Act. We will require this form to be signed to continue treatment with you. If you have any questions, or if there is anything that you need addressed before feeling comfortable signing this form, please do not hesitate to reach out at cameron@mendingspacephl.com

Thank you and we wish you the best in your journey,

Cameron Cready-Pyle, LCSW
Laura Farrell, LMSW
Jenna Spitz, LMSW

The No Surprises Act
Standard Notice & Consent, 1/5

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.

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 healthcare 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.

The No Surprises Act
Standard Notice & Consent, 2/5

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Total cost estimate of what you could 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 4 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 610-756-9880 or write to contact@mendingspacephl.com.**
- **Questions about your rights? Contact the Pennsylvania Secretary of State at 717-787-6458.**

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-againstsurprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

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The No Surprises Act
Standard Notice & Consent, 3/5

OMB Control Number: 0938-1401

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 items or services from:

- ☐ **Cameron Cready-Pyle, LCSW**
- ☐ **Laura Farrell, LMSW**
- ☐ **Jenna Spitz, LMSW**

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 given written notice at intake 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 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 will not treat you.

Services Provided	Cost per session
90791: Diagnostic Evaluation, 60 minutes	
90837: Psychotherapy, 60 minutes	