Midwest Psychological Services

10820 Sunset Office Drive, Suite 120, Sunset Hills, Missouri 63127

• Phone: (314) 319-3148 • Fax: (888) 920-1342 • Email: info@midwestpsychservices.com

A great place to grow.

THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT DOCUMENTS
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 pay for out-of-network care.

IMPORTANT

You are not required to sign this form and should not sign it if you did not have a choice of health care provider when you received care. You may choose to get care from a provider or facility in your health plan's network, which may cost you less. If you would like assistance with this document, please ask Ms. Donna McNamara, Care Coordinator at the Midwest Psychological Services.

Take a picture and/or keep a copy of this form for your records.

You are receiving this notice because the Midwest Psychological Services LLC is not in your health plan's network. This means the Midwest Psychological Services LLC does not have an agreement with your plan.

Getting care from this provider or facility may cost you more.

If your plan covers the service you are receiving, 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 Ms. Donna McNamara, Care Coordinator at the Midwest Psychological Services, if you need help knowing if these protections apply to you. She may be contacted at (314) 319-3148.

If you sign this form, you may pay more because:

- 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.

Cost Estimate

Client name: _____

Out-of-network provider(s) or facility name: **Midwest Psychological Services, LLC**

Total cost estimate of what you may be asked to pay: It is your 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 pages 3-4.

► **Review your detailed estimate.** See pages 3-4 for a cost estimate for each 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: Ms. Donna McNamara, Care Coordinator, at (314) 319-3148 to address your questions and concerns.

► **Questions about your rights?** Contact: The Missouri Secretary of State at (573) 751-4936

More Information about Your Rights & 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, you agree that you may pay more for out-of-network care.

With your signature, you are agreeing to receive services from the Midwest Psychological Services, LLC

With your signature, you acknowledge that you are consenting of your own free will and are not being coerced or pressured. You also understand that:

- You may receive a bill for the full charges for these services or have to pay out-of-network cost-sharing under your health plan.
- You were given a written notice on _____ explaining that the Midwest Psychological Services LLC is not in your health plan's network, the estimated cost of services, and what you may owe if you agree to be treated by this provider or facility.
- You received the notice either on paper or electronically, consistent with your choice.
- You fully and completely understand that some or all amounts you pay might not count toward your health plan's deductible or out-of-pocket limit.
- You may end this agreement by notifying the Midwest Psychological Services LLC in writing.

_____

Client Name (≥ 7 y.o.)/Signature/Date

_____

Legal Guardian Name/Signature/Date

_____

Provider Name/Signature/Date

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FEDERAL TAX ID: 84-4155129
GROUP NPI#: 1366076721

Client Name: _____

Client Date of Birth: _____

Out-of-Network Facility Name: **Midwest Psychological Services, LLC** _____

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the costs of the services listed. It does not include any information about what your health plan may cover. Dr. Debra Zand, owner and clinical director of the Midwest Psychological Services, will collaborate with you to determine how many sessions and/or services you may need to receive the greatest benefit based on your presenting clinical concerns.

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	$300.00
	90832	Psychotherapy, 30 minutes	$100.00
	90834	Psychotherapy, 60 minutes	$200.00
	90846	Family Psychotherapy without Patient Present, 60 minutes	$200.00
	90847	Family Psychotherapy with Patient Present, 60 minutes	$200.00
	96130, 96131, 96136, 96137	Psychological and Neuropsychological Testing, Feedback (by Psychologist)	$300.00/hour
	96138, 96139	Psychological and Neuropsychological Testing, & Scoring (by Psychometrician)	$150.00/30 minutes
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	Cancellation Fee	Your Therapist Requires a 24-Hour Notice of Cancellation for Therapy Services	$200

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress &)
	Legal Fees	Includes: time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.	$400.00/hour
	Production of Records	Please note that the fee for preparation of records is governed by Missouri Revised Statute 191.227. As of 2/1/2025, f**ees for copying will be $29.47 plus $0.68 per page or $129.16 total, whichever is less, for copies provided electronically.** The fees charged are adjusted annually based on the Consumer Price Index for All Urban Consumers (CPI-U). This rate applies to requests made by clients or their personal representative. A personal representative is an individual authorized to make patient healthcare decisions. For more information regarding your rights under HIPAA to access your health information, please see: https://www.hhs.gov/hipaa/forprofessionals/privacy/guidance/access/index.html.	
	Total Estimate:		

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