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 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.

See the next page for your cost estimate.

Estimate of what you could pay.

Patient name: _____

Out-of-network provider(s) or facility name: **J. Russell Ramsay, Ph.D., ABPP**

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 five 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, including out-of-network benefits.

► **Questions about this notice and estimate?** Call Dr. Ramsay at 267.450.7705 or e-mail him at ramsay@cbt4adhd.com to arrange a phone call to address your questions.

► **Questions about your rights?** Contact: Commonwealth of Pennsylvania Dept. of State, Bureau of Professional and Occupational Affairs at ST-PSYCHOLOGY@PA.GOV or 717.783.7155

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 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 (select all that apply):

X J. RUSSELL RAMSAY, PH.D., ABPP

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 [MM.DD.YYYY] 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 will not treat 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.

J. Russell Ramsay, Ph.D., ABPP
130 N. Main Street, #430
Sellersville, PA 18960
PH: 267.450.7705, ramsay@cbt4adhd.com, www.cbt4adhd.com

FEDERAL TAX ID: 37-2047613
NPI#: 1255350690

More details about your estimate

Patient name: _____

Date of Birth: _____

Diagnosis: Z65.9 Problem related to unspecified psychosocial circumstances

Out-of-network provider name: J. RUSSELL RAMSAY, PH.D., ABPP

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 (Effective JULY 1, 2024)

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 (typically 1.5 - 2 hours)	$500
	90832	Psychotherapy, 16-37 minutes	$150
	90834	Psychotherapy, 38-52 minutes	$225
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$225
	90847	Family Psychotherapy with Patient Present, 50 minutes	$225
	Late Cancellation/ No Show Fee	Dr. Ramsay Requires a Less Than 24-Hour Notice Cancellation Fee	Full fee for missed session: either $150 or $225
	Diagnostic Evaluation Report Writing	Written documentation of initial diagnostic evaluation summary, if requested (2 hrs.)	$450
	Legal Fees Consultation	Expert witness testimony/Reports/Records Professional Consultation	$300/hour
	Total Estimate:	This Good Faith Estimate explains Dr. Ramsay's rate for each service provided. Dr. Ramsay 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) and/or presenting clinical concerns.	

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