Grayson Psychiatry

No Surprises Act 2025

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.

Out of network facility: Grayson Psychiatry
Here are my standard service codes and costs:
- Intake fee- 99203/90838 $950
- Follow up-

o 90838- $365- 60 min
o 90833- $265- 30 min
o Physician services $90- 15 min

Here are my estimates for you:
- 2 part Intake: $895 and $395
- Follow ups: $365 per session depending on frequency and lengths of follow ups, which are determined by clinical need, and can range from every other week to every 6 months for medication management (every 3 months if patient is on a controlled substance).

The amount above 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.

Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
Questions about this notice and estimate? Call (704) 286-1129

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care. With my signature, I am saying that I agree to get the items or services from: Grayson Psychiatry

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 [enter date of notice] 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 might not treat you. You can choose to get care from a provider or facility in your health plan’s network.

Patient First Name

Patient Last Name

Patient Date of Birth

Parent/Legal Guardian First Name (if applicable)

Parent/Legal Guardian Last Name (if applicable)

Patient (or Parent/Legal Guardian) Signature

Date