Jessica Sauer, LCSW
Brand New Day Counseling, LLC
924 North Magnolia Avenue #350 Orlando, FL 32803
Phone: (407) 733-5392
FEIN: 81-2871319 • NPI#: 1427363845 • www.brandnewdaycounseling.net

GOOD FAITH ESTIMATE FORM/NOTICE REGARDING PROTECTIONS AGAINST SURPRISE BILLING (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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your insurance plan to provide services. **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 surgicalcenter without your knowledge or consent to receive a higher bill.

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 from higher bills.
-You may owe the full costs billed for the items and services you get.
-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.

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 to lower your costs. See the next page for your cost estimate.

Effective 12/15/2023-05/31/2025 and moving forward, until CMS provides an updated form

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ESTIMATE OF WHAT YOU COULD PAY

Client name: _____

Date of Birth: _____

Diagnosis Code: _____

Out-of-network provider(s) or facility name: **Jessica Sauer, LCSW of Brand New Day Counseling, 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 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 Jessica Sauer, LCSW at (407) 733-5392.
- **Questions about your rights?** Contact The Florida Department of Health's Division of Medical Quality Assurance, https://mqa-flhealthcomplaint.doh.state.fl.us/ or call (850) 488-0595. You can also visit https://www.cms.gov/nosurprises/consumer-protections/What-are-the-new-protections for more information about your rights under Federal law. The federal phone number for information and complaints is: 1-800-985-3059.

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.

Understanding your options

You can get the items or services described in this notice from providers who are in-network with your plan. Please contact your health plan for more information.

More information about your rights and protections
Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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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 Jessica Sauer, LCSW of Brand New Day Counseling, LLC.

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 _____ 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, but you can choose to get care from a provider or facility that's in your health plan's network.

_____ or _____

Client's signature | Guardian/authorized representative's signature

_____ or _____

Printed name of client | Printed name of guardian/authorized representative

_____ or _____

Date and time of signature | Date and time of signature

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Take a picture or keep a copy of this form.
It contains important information about your rights and protections.

GOOD FAITH ESTIMATE TABLE OF SERVICES AND FEES

Client Name: _____

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 information about what your health plan may cover. This means that the final cost of services may be different (less) than this estimate. Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Date of Service (if known)	Service code (CPT Code)	Description	Fee for Service (number of sessions will be determined as we assess your needs)
	90791/90837	Initial Assessment/Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$125.00
	Late Cancelation/No Show Fee	24-Hour notice of cancelation is required. If this policy isn't observed, you will incur a Late Cancellation/No Show Fee. You are responsible for the fee of the appointment missed	$75.00
	Production of Records	Copies and/or summaries of records	$.25/paper page plus postal fees if you would like your copies mailed. Summaries are billed at the regular hourly rate of $125.00
	Letters	Letters for school or employment matters, 504 plans, Emotional Support Animals, or anything other issues related to our treatment together	Prorated at the hourly rate of $125.00
	Legal Fees	All professional time, including preparation and transportation costs, even if I am called to testify by another party. I charge $250 per hour *in advance*	$250.00/hour

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		for preparation and attendance at any legal proceedings.	
	Total Estimate:	TOTAL ANNUAL COST ESTIMATE OF HOURLY SESSIONS (90837), EVERY _____ WEEKS @ $125 x _____ WEEKS FOR THE REMAINDER OF 2025 (ACCOUNTING FOR TIME OFF)= $_____ Your therapist 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)/presenting clinical concerns.	
Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.			