The No Surprises Act Standard Notice and Consent Document

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protection from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care. 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 insurance plan covers the item or service you are 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 below for your cost estimate.

Estimate of What You Could Pay

Out-of-network provider(s) or facility name(s): A Centered Life, LLC

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 below.

1. **Review your detailed estimate.** See below for a cost estimate for each item or service.
2. **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.
3. **Questions about this notice and estimate?** Call 316-209-4455 or email support@acenteredlife.org
4. **Questions about your rights?** Contact the Secretary of State of Kansas (https://sos.ks.gov/contact)

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 receive them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

For more information about your rights and protections visit: Model Disclosure Notice Regarding Patient Protections Against Surprise Billing (cms.gov)

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

Company Name	Address	Phone Number	Email	Website
A Centered Life, LLC	300 W. Douglass, 122 Wichita, KS 67202	316-209-4455	support@acenteredlife.org	www.acenteredlife.org
Federal Tax ID	99-5059402	**Group NPI #**	1912729351	

GOOD FAITH ESTIMATE 2025

TABLE OF SERVICES AND FEES

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not 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. If you do not have insurance, discuss with your therapist the option of a sliding fee scale.

Please note: Master level interns, students, and some pre-clinical licensed clinicians are not able to bill insurance.

The following table includes the rates for the services provided at this practice. The total fee will depend on the number of sessions/services provided. For example, a year of weekly individual therapy (90837) with a Master's level (MA) intern may cost approximately $3120 total. The client and clinician will discuss the number of sessions needed, and the client has the right to withdraw from services at any time.

Service code (CPT Code)	Description	Fee of Service (Number of sessions will be determined by client and clinician)
90791	**Initial Diagnostic Evaluation** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level: $40 $200 $225
90834	**Psychotherapy, 38-52 minutes** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level: $40 $160 $180
90837	**Psychotherapy 53+ minutes** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level $40 $175 $200

90839	**Psychotherapy for a Crisis (30-74 mins)** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	$40 $175 $200
90846	**Family Psychotherapy without Client Present (50 mins)** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level: $40 $175 $200
90847	**Family Psychotherapy with Client Present (60 mins)** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level: $40 $175 $200
90853	**Group Psychotherapy** MA- Intern LPC/LCPC, LSW/LCSW, LMFT/LCMFT, LCP PhD/PsyD	Based on Clinician Level $40 $75 $75
96130-96133, 96136-96139	**Psychological and Neuropsychological Testing** PhD/PsyD/LCP	$100 - $250 per unit
Materials Fee	**Psychological and Neurological Testing Materials**	$75 per full assessment battery
90785	**Interactive Complexity** Add-on code to account for challenges and additional needs in-session.	$25
Cancellation Fee	**This clinic has a 24 hour cancellation fee**, which you will be charged for canceling a session under 24 hours from the scheduled appointment or showing up too late for the full service to be provided.	$50
Production of Records/Letters	Record or letter production may incur additional prorated fees based on time required by the clinician outside of session. This proration will be based on the hour fee as seen for CPT code 90837.	Prorated based on hours of service provided.
Legal Fees	Your clinician may use prorated fees to bill for addressing legal issues, such as appearing in court. This proration will be	Prorated based on hours of service provided.

	based on the hour fee as seen for CPT code 90837.	
Consultation and Other Services	Your clinician may use prorated fees to bill for time spent outside of session (e.g., a phone call with your child's school per your request). This proration will be based on the hour fee as seen for CPT code 90837.	Prorated based on hours of service provided
Total Estimate:	This Good Faith Estimate explains your clinician's rate for each service provided. Your clinician 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. Tele-mental Health) is not delineated above since the charges are identical.		