**THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT DOCUMENTS**

**Beacon Counseling does not accept insurance of any kind as payment for services.** We are able to accept Health Savings Account (HSA) and Flexible Savings Account (FSA) cards as well as cash, check, and credit cards via Square in office and Realm online payment system.

**Information that you may need if submitting for out-of-network reimbursement:  
Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client Diagnosis:** Z65.9 Problem related to unspecified psychosocial circumstances \*\**NOTE: It is unethical to make a diagnosis prior to seeing a client, so additional diagnoses may be added to the treatment plan during the course of treatment.*

**Out-of-Network Provider (Clinician’s Name and Title):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Out-of-Network Provider NPI # (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Out-of-Network Facility:** Beacon Counseling Center 202 Industrial Court, Wylie, TX 75098

**Federal Tax ID for Beacon Counseling (Ministry of The Cross Church/First Baptist Wylie):** 75-0939923

**Total cost estimate of what you may be asked to pay:** \*\*\*Please know that it is your right to determine your goals for treatment and how long you would like to remain in treatment. Please review the breakdown of fees on the following pages.\*\*\*

As a general summary our fees are $100.00 per 50 minute session for fully licensed clinicians and $85.00 per 50 minute session for licensed professional counseling associates. Our student interns charge between $20-50.00 based on experience and specializations. Please see the “Good Faith Estimate: Table of Services and Fees” on the following page to calculate costs further. Fees are subject to change annually and new consents will be required upon any change of fees for service.

* **Review your detailed estimate.**  See detailed fees for services on the final page.
* **Call your insurance health plan.** Your plan may have better information about how much of these services are reimbursable.
* **Questions about this notice and estimate?** Call 469-825-1100, the general Beacon Counseling phone line, for additional information.
* **Questions about your rights?** Contact the Texas Behavioral Health Executive Council at (512) 305-7700 or by sending a letter to George H.W. Bush State Office Building 1801 Congress Ave., Ste. 7.300 Austin, Texas 78701
* **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.

**GOOD FAITH ESTIMATE: TABLE OF SERVICES AND FEES**  
Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **Service code**  **(CPT Code)** | **Description or Additional Information** | **Fee for Service**  **(Number of Sessions Will Be Determined as We Progress)** | | |
|  |  | **LPC / LMFT / LCDC** | **Associate** | **Student Intern** |
| 90791 | Initial Diagnostic Evaluation | $100.00 | $85.00 | $20.00-$50.00 |
| 90832 | Psychotherapy, 16-37 minutes | $100.00 | $85.00 | $20.00-$50.00 |
| 90834 | Psychotherapy, 38-52 minutes | $100.00 | $85.00 | $20.00-$50.00 |
| 90837 | Psychotherapy ≥ 53 minutes (i.e. 90 minute sessions) | $150.00 | $127.50 | $20.00-$50.00 |
| 90839 | Psychotherapy for a Crisis (30-74 minutes) | $100.00 | $85.00 | $20.00-$50.00 |
| +90840 | Psychotherapy for a Crisis  (code for each additional 30 mins) | $50.00 | $50.00 | $50.00 |
| 90846 | Family Psychotherapy without Patient Present, 50 minutes | $100.00 | $85.00 | $20.00-$50.00 |
| 90847 | Family Psychotherapy with Patient Present, 50 minutes | $100.00 | $85.00 | $20.00-$50.00 |
| 90853 | Group Psychotherapy | Fee based on number of group members, set prior to the start of the group | | |
| 98966-98968 | Telephone Assessment & Management | $25 per 15-minute increment | | |
| 98970-98972 | Online Digital Evaluation & Mgt -  Responding to Email & Text Messages | $25 per 15-minute increment | | |
| **Cancellation Fee** | We Require 24-Hours Notice to Avoid a Cancellation Fee | You are Responsible for the **Full Fee** of the Appointment if not cancelled 24 hours in advance | | |
| **School / Letters** | $25 per 15 minutes of attendance in person or online at an IEP or ARD meeting,  $25 per 15 minutes of time reviewing notes and writing letters. | | | |
| **Production of Records** | $25 for pages 1-20, with additional pages charged at $0.25 per page. | | | |
| **Legal Fees** | $200 per hour for preparation and attendance at proceedings,  $4,000 retainer required up front if court appearances occur. | | | |
| **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. telemental health) is not delineated above since the charges are identical.

**By signing below, I understand that Beacon Counseling does not accept insurance 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:

* Christine Culp, LMFT Associate
* Dalila Nastase, LPC
* Dana Roberts, LPC
* John Gambill, LCDC and LPC Associate
* Liesal Miller, LMFT
* Liz McQueen, LPC
* Malia Nompone, LPC
* Marissa Berry, Counseling Student
* Misti Compton, LPC
* Nicole Rodriguez, LPC and LCDC-I
* Sarah Davis, LPC
* Scott Wakeem, LPC

With my signature, I acknowledge that I am consenting to the following:

* 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 the date listed below explaining that my provider or facility is not 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 received 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.

IMPORTANT: You DO NOT have to sign this form, but if you do not sign this provider or facility may not be able to administer treatment.

Client name (printed) Client’s signature

Name of Guardian/Authorized Representative (printed) Signature of Guardian/Authorized Representative

Date signed Clinician Signature

**Take a picture and/or keep a copy of this form.   
It contains important information about your rights and protections.  
\*\* This form expires annually and must be signed again at the start of each year \*\***