Thrive Therapy Associates, LLC

NO SURPRISES ACT / GOOD FAITH ESTIMATE

Congress enacted the No Surprises Act (the Act) on December 27, 2020 as part of the Consolidated Appropriations Act of 2021. The purpose of the No Surprises Act is to reduce the occurrence of surprise billing and to protect patients from its ensuing financial hardship. Surprise billing occurs when a patient receives an unexpected medical bill for services the patient received from a health care provider that is not covered by the patient's health insurance. This commonly occurs when a patient seeks treatment from a health care facility that may be covered by the patient's health insurance; however, while at the facility, the patient ends up being treated by a provider at the facility who is not covered by the patient's health insurance (unbeknownst to the patient). Typically, this occurs because the provider is an independent contractor of the facility who is not credentialed by the same insurers as the facility itself.

In addition to strengthening safeguards against surprise billing for those who have health insurance, the Act was intended to provide better protection to uninsured and self-pay patients, who are more likely to be impacted by an unexpected medical bill. To that end, Section 2799B-6(2) (Section 112 of the Act) was added to Public Health Services Act, which requires **health care providers and health care facilities, upon scheduling an item or service or upon request of an individual, to inquire about such individual's health coverage status and to provide a notification of the good faith estimate of the expected charges for furnishing such item or service.**

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.

Good Faith Estimate of What You Could Pay

Thrive Therapy Associates, LLC
8860 Sweetshade Drive
Lewis Center, OH 43035
NPI: 1245693324
Tax ID: 811004293

►**Review your detailed estimate.** See below for a cost estimate for each item or service you'll get.
►**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 Arlyn Althoff at 614-607-4032.
►**Questions about your rights?** Contact the No Surprises Help Desk at 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 also get the items or services described in this notice from providers who are in-network with your health plan.
More information about your rights and protections
Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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.**

Patient Name: _____ Date of Birth: _____

Service Code	Description	Estimated Amount to be Billed
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder	$60.00 per 30-minute session $90.00 per 45-minute session $120.00 per 60-minute session
Total Estimate of What You May Owe:		$3,140.00 per year for weekly 30-minute sessions $4,680.00 per year for weekly 45-minute sessions $6,240.00 per year for weekly 60-minute sessions

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 Thrive Therapy Associates, 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 prior to starting services 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.

_____ _____
Signature of Patient's Guardian/authorized representative Print name of Patient's 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.