Willow Tree Counseling, PLLC
102 W. Beaton Dr., Ste. 103
West Fargo, ND 58078
Ph: 701-730-8313
www.willowtreecounselingfm.com
support@willowtreecounselingfm.com

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 formand 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.

Estimate of what you could pay

Patient name:____

Out-of-network provider(s) or facility name: Willow Tree Counseling, PLLC. *or*

Erin Grahn, MA, LPCC, LMAC *or* Andrea Klobuchar, MA, LPCC.

Total cost estimate of what you may be asked to pay:	$

► **Review your detailed estimate.** See Page 4 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: Erin Grahn, Director of WTC
Ph: 701-730-8313.

► **Questions about your rights?**
Contact:

- No Surprises Held Desk at :
  (800) 985-3059

- North Dakota Insurance Department at:
  Email: insurance@nd.gov
  600 E Boulevard Ave.
  Bismarck, ND 58505-0320
  (701) 328-2440
  (701) 328-4880 Fax
  (800) 247-0560 Consumer Hotline
  (800) 366-6888 TTY Line

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.

More information about your rights and protections

Visit https://cms.gov/nosurprises for more information about your rights under federal law.

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 (select all that apply):

☑ *Erin Grahn, MA, LPCC, LMAC*

☑ *Andrea Klobuchar, MA, LPCC*

☑ *Willow Tree Counseling, PLLC.*

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.

____	or	____
Patient's signature		Guardian/authorized representative's signature
____		____
Print name of patient		Print name of 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.

Willow Tree Counseling, PLLC
102 W. Beaton Dr., Ste. 103
West Fargo, ND 58078

Ph: 701-730-8313
www.willowtreecounselingfm.com
support@willowtreecounselingfm.com

Federal Tax ID: 81-3221115
Group NPI: 1497293799
Erin Grahn NPI: 1669751962
Andrea Klobuchar NPI: 1033477021

More details about your estimate

Patient name: ____

Out-of-network provider(s) or facility name:

☑ *Erin Grahn, MA, LPCC, LMAC*

☑ *Andrea Klobuchar, MA, LPCC*

☑ *Willow Tree Counseling, PLLC.*

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.

Good Faith Estimate

Client:__________________________

Date:__________________________

Table of Services and Fees

Effective November 1,2019 to January 31, 2025

Fee Schedule - LPCC - Mental Health Services			
Date of Service (if known)	***Fee for Service***	***Service Code (CPT Code)***	***Description***
	$125.00	90832	16-37min individual psychotherapy session
*	$150.00	90834	38-52min individual psychotherapy session
	$175.00	90837	53+min individual psychotherapy session
	$150.00	90846	45min Family Therapy w/out Client Present
	$150.00	90847	45min Family Therapy w/Client Present
	$150.00	90839	Crisis Session 30-74min
*	$225.00	90791	Mental health diagnostic assessment
Fee Schedule - LMAC - Substance Use Services			
Date of Service (if known)	***Fee for Service***	***Service Code (CPT Code)***	***Description***
	$125.00	90832	16-37min individual psychotherapy session
	$150.00	90834	38-52min individual psychotherapy session
	$175.00	90837	53+min individual psychotherapy session
	$150.00	90846	45min Family Therapy w/out Client Present
	$150.00	90847	45min Family Therapy w/Client Present
	$150.00	90839	Crisis Session 30-74min
	$15.00	UA-MP	Multipanel Urineanalysis
	$10.00	UA-ETG	ETG urineanalysis
	$225.00	90791	Substance use diagnostic assessment
Other Fees - Applicable to all appointments			
Date of Service (if known)	***Fee for Service***	***Service Code***	***Description***
*	$50.00	LC	Late Cancellation
	**	NCNS	No-call/No-show fee ***Rate based on the service code scheduled for.*
	$35.00	CR	Copy of clinical record
	$175.00*	LF-C	*Prorated based on the hourly rate for legal fees and/or consultation. This includes time needed to prepare.
Total estimate of what you *may* owe:	**$**		***This Good Faith Estimate explains your provider's rate for each service provided. Your provider 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 diagnoses and presenting clinical concerns.***

1) Estimates are based on being seen 1x/week over the course of 12 weeks. This may be more or less based on specific concerns.

2) Please note that Place of Service (in-office vs. telehealth) is not delineated above as the charges are identical.

3) Billing codes that have a fee of zero are omitted from this document.

4) The fees listed apply to all providers at Willow Tree Counseling. The fees, based on the professional license of your provider, are the same regardless of the provider.

5) This is an estimate only. You will be notified in advance if WTC's fee schedule changes.

Good Faith Estimate

Table of Services and Fees

Effective February 1, 2025

Client:____________________________

Date:____________________________

Fee Schedule - LPCC - Mental Health Services			
Date of Service (if known)	***Fee for Service***	***Service Code (CPT Code)***	***Description***
	$150.00	90832	16-37min individual psychotherapy session
*	$175.00	90834	38-52min individual psychotherapy session
	$200.00	90837	53+min individual psychotherapy session
	$175.00	90846	45min Family Therapy w/out Client Present
	$175.00	90847	45min Family Therapy w/Client Present
	$200.00	90839	Crisis Session 30-74min
*	$250.00	90791	Mental health diagnostic assessment
Fee Schedule - LMAC - Substance Use Services			
Date of Service (if known)	***Fee for Service***	***Service Code (CPT Code)***	***Description***
	$150.00	90832	16-37min individual psychotherapy session
	$175.00	90834	38-52min individual psychotherapy session
	$200.00	90837	53+min individual psychotherapy session
	$175.00	90846	45min Family Therapy w/out Client Present
	$175.00	90847	45min Family Therapy w/Client Present
	$200.00	90839	Crisis Session 30-74min
	$20.00	UA-MP	Multipanel Urineanalysis
	$15.00	UA-ETG	ETG urineanalysis
	$250.00	90791	Substance use diagnostic assessment
Other Fees - Applicable to all appointments			
Date of Service (if known)	***Fee for Service***	***Service Code***	***Description***
*	$50.00	LC	Late Cancellation
	**	NCNS	No-call/No-show fee ***Rate based on the service code scheduled for.*
	$35.00	CR	Copy of clinical record
	$200.00*	LF-C	*Prorated based on the hourly rate for legal fees and/or consultation. This includes time needed to prepare.
Total estimate of what you *may* owe:	**$**		***This Good Faith Estimate explains your provider's rate for each service provided. Your provider 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 diagnoses and presenting clinical concerns.***

1) Estimates are based on being seen 1x/week over the course of 12 weeks. This may be more or less based on specific concerns.

2) Please note that Place of Service (in-office vs. telehealth) is not delineated above as the charges are identical.

3) Billing codes that have a fee of zero are omitted from this document.

4) The fees listed apply to all providers at Willow Tree Counseling. The fees, based on the professional license of your provider, are the same regardless of the provider.

5) This is an estimate only. You will be notified in advance if WTC's fee schedule changes.