LAUREL PSYCHIATRY

84 Neron Place
New Orleans, LA 70118
Office: (504) 229-2368
Fax: (380) 390-5218
Email: admin@laurelpsychiatry.com

FEE AGREEMENT AND GOOD FAITH ESTIMATE

About the No Surprises Act

Effective January 1, 2022, all healthcare providers are required to notify patients of their federal rights and protections against 'surprise billing.' The purpose of the Act is to protect you from unexpected medical bills. This Act requires you to be notified of your federally protected rights to receive a notification when services are rendered by an out-of-network healthcare provider, if you are uninsured, or if you elect not to use your insurance.

In case any of these situations apply to you, I am required to provide you with a 'Good Faith Estimate' of the cost of services to you. This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

If you are billed $400 or more above this Good Faith Estimate, you have the right to dispute the bill. You may contact my office to let me know the billed charges are higher than the Good Faith Estimate. You can ask me to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the

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dispute process, visit http://www.cms.gov/nosurprises or call 1-877-696-6775.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.

Practice and Provider Information

- Practice Name: Laurel Psychiatry, LLC
- EIN/Tax ID: 93-4224182
- Address: 84 Neron Place, New Orleans, LA 70118
- Provider Name: Antoinette Laurel, DO
- Provider NPI: 1821521436

Details of Typically Provided Services and Rates

- Psychiatric Diagnostic Evaluation with Medical Services, 60-90 Minutes
    - CPT Code(s): 90792, 99204, 99205 + 99417
    - Estimated Quantity in 12 Months: _____ (range 0-1)
    - Standard Rate: $400-600
- 99213 OR 99214: Evaluation and Management, Low-Moderate Complexity
    - Estimated Quantity in 12 Months: _____ (range 4-12)
    - Standard Rate: $200
- 99215: Evaluation and Management, High Complexity
    - Estimated Quantity in 12 Months: _____ (range 4-12)
    - Standard Rate: $300
- 90834: Psychotherapy, 45 Minutes
    - Estimated Quantity in 12 Months: _____ (range 12-45)
    - Standard Rate: $300

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Patient Information

Patient Name: _____
Patient Date of Birth: _____
Patient Address: _____
Patient Diagnosis/Diagnoses (ICD-10 Codes): _____
Dates of Service: To Be Determined
Date of Good Faith Estimate: _____
Total Estimated Cost (12 Months): _____

Acknowledgement of Receipt of Fee Agreement & Good Faith Estimate

- With my signature, I acknowledge that I am consenting of my own free will. I also understand that:
- I am giving up some consumer billing protections under federal law.
- I agree to pay the full fee for an associated service at the time of my treatment, unless otherwise arranged.
- I was given a written notice explaining that my provider 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.
- I fully 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 at any time by notifying the provider in writing.

Signature: _____
Printed Name of Person signing form and relationship to patient if signing on their behalf:
_____
Date: _____