The Wellness Seed, PLLC

5 Northern Blvd, Ste 14

Amherst, NH 03031

T: (603) 864-0141

F: (603) 417-6902

Website: www.wellness-seed.com

The Wellness Seed, PLLC / Jill C. Fimbel, MA LCMHC

**Surprise Billing Protection Form**

The purpose of this document is to inform you of 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. You are receiving this notice because this provider or facility is not in your health plan’s network, meaning the provider or facility does not have an agreement with your plan.

You are not required to sign this form and should not 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.

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
* 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 should not 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.

Estimated Payment

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name: The Wellness Seed, PLLC Provider Name: Jill C. Fimbel, LCMHC

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

$245/55 min initial intake session

$140/55 minute session follow up session

$105/45 min follow up session

$70/30 min follow up session

$70/missed apnt, no show fee

►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 or email: Jill C. Fimbel, LCMHC, (603) 864-0141, WellnessSeedTherapy@gmail.com,

►Questions about your rights? Contact the New Hampshire Board of Mental Health 603-271-2702

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

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 Jill C. Fimbel, LCMHC (provider) at The Wellness Seed, PLLC (facility).

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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 must pay out-of-network

cost-sharing under my health plan.

• I was given a written notice by January 25, 2023 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.

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**Signature** of patient or guardian/authorized representative

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**Printed** name of patient or guardian/authorized representative

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Date and time of signature