No Surprises Act/ Good Faith Estimates

Billing and Rate Information

$200 Initial Intake Sessions
$180 per follow-up sessions

We accept BCBS PPO and HMO through the Endeavor Network

*All sessions are 53 minutes in duration and are for individual, couples and/or family sessions. This does not include therapy intensive costs, which may vary by package or group therapy fees.

Reduced rate sessions may be available and are determined by our financial assistance policy .

Sessions are currently offered in person and via telehealth depending on the clinician. Telehealth sessions are held via a secure, confidential platform.

Free 15 minute Consultation

If you are interested but unsure if therapy is right for you, please call our office or complete the online appointment request form to set up a free 15-minute phone consultation with one of our clinicians.

Insurance

We are in-network with the following health insurance plans:

- Blue Cross Blue Shield PPO
- Blue Cross Blue Shield HMO (Endeavor Health)
- Blue Choice/Options

If you would like to work with one of our clinicians but have different insurance, you are welcome to submit sessions for possible out of network reimbursement. Some insurance companies are willing to reimburse our clients a portion of the costs for each session. We can supply you with an itemized statement (superbill) for each fully paid session, which you can submit along with your claim to your health insurance provider for reimbursement. There is no guarantee that the insurance provider will accept a portion or the full cost of services. You are responsible for providing payment for the rates listed above at the time of service. Contact your insurance provider to see if they accept out-of-network provider billing statements.

Reduced Fee
Reduced fee services are available on a limited basis upon request. Fees vary by provider and are based on client need.

Payment
All payment is due in full at the time of service. We accept personal checks, company flexible spending account or health savings account debit cards, (FSA & HSA) and major credit cards (i.e., MasterCard, Discover, AMEX, & VISA). All clients must have a current credit card on file and payment will be processed after your session. Please note, there is a $50 fee for any returned checks and a $30 fee for any chargeback/disputed charge for a balance that was charged as a result of your services rendered that resulted in your personal responsibility.

Cancellation Policy
We ask that you give us at least 24 hours notice when canceling or rescheduling an appointment or you are subject to a cancellation or "no show" fee, which will be billed directly to your credit card on file for the rate listed above.

Notification of Federal Protections against Surprise Billing

Good Faith Estimate for Uninsured clients
You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. If you are a self-pay client, defined as someone who will not be billing insurance through us and/or submitting a claim through their OON insurance company, Celeste Genevieve Counseling shall provide you a Good Faith Estimate in writing prior to your session, and will additionally provide upon request. If you receive a bill that is substantially higher (more than $400) than estimated on your Good Faith Estimate, you can dispute the bill. It is a good idea to save a copy of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit:
www.cms.gov/nosurprises

For Out-of-Network clients
If you have an insurance plan for which we are not in network and choose to work with us, getting care from this provider or facility could cost you more than if you went to an in-network provider.

If your insurance plan covers the item or service you are 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 healthcare provider or patient advocate if you need help knowing if these protections apply to you.

According to federal regulations, a waiver can be signed to pay the full fees, which may be more than your in-network benefits, which may mean you have given 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 toward your deductible and out-of-pocket limit. Contact your health plan for more information regarding your out of network benefits.

You should not sign any waivers if you did not have a choice of providers when receiving care. For example, a doctor was assigned to you with no opportunity to make a change (or without choice). Before deciding whether to sign a waiver, 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 a provider or facility.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay (*in network rate*) and the full amount charged (*private fee*) for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in network cost-sharing amount (such as copayments, deductible, and coinsurance). You can't be “balance billed” for these

emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance filed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't "balance bill" you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization),
- Cover emergency services by out-of-network providers,
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits,
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For more information about your rights under federal law, visit:
https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements