Robin May-Davis Psychiatry P.A.
2224 Walsh Tarlton Ln. #110 Austin TX 78746
512-291-6370 phone 512-291-6507 fax
Robin.maydavis@gmail.com www.robinmaydavismd.com

No Surprises Act Notification

Dear Patient:

In Compliance with the No Surprises Act that went into effect on January 1, 2022, all healthcare providers including psychiatrists and therapists are required to notify patients of their federal rights and protections against "surprise billing." The purpose of the Act and of this document is to protect you from unexpected medical bills.

This Act requires that I notify you of your federally protected rights to receive a notification *when services are rendered by an out-of-network psychiatrist (as I am), 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. Doing so is particularly challenging in mental health care because it is difficult to predict the length of treatment, and because patients have the right to decide how long they want to participate. Therefore, I describe below the fees that typically apply for the types of services I offer, including for your condition. Going forward, we can collaborate on a regular basis to determine how many sessions you may need.

My current fee schedule:

- Initial diagnostic, psychiatrist evaluation (usually 100-120 minutes): $500
- 50-60 minute follow up with or without psychotherapy (individual): $290, with discount to $265 if meeting at least monthly.
- 20-30 minute follow up with or without psychotherapy (individual): $200
- Reports & Document preparation fees will be up to $100 per 20min
- Missed visits are up to the full fee of the visit if not canceled within 24hrs
- Phone calls at unscheduled times will be up to $100 per 20min.
- Legal related expense is $2500/day to testify or be available to testify
- I sometimes order labs, consultations or outside studies and treatments- but I cannot guarantee the fees for these treatments. Please seek information directly from these outside businesses.
- These fees apply to all DSM diagnostic codes of the American Psychiatric Association.
- I use diagnostic codes that are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done once or twice weekly, but sometimes more or less often.
- Most often therapy continues for six months, one year, or several years., but check with me about your. Medication and lifestyle management can often be ongoing for years. As noted above, because of this variability, please ask me what can be expected in your case.

- Most often medication management is done anywhere from every 1-3 week during initial stabilization or during a flare to every 3months for routine maintenance care. .
- Most often medication management continues for several years or even longer; because of this variability, please ask me what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy/treatment.

Required Disclaimers:

- Should you have additional questions about your rights under this act, you can contact any of the following: The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit <https.//www.cms.gov/nosurprises> for more information about your rights under federal law. The Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431.
- If you are billed for more than the Good Faith Estimate you have the right to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution, you must start the process within 120 days (about 4 months) 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 healthcare provider, you will have to pay the higher amount.

Sincerely,

Robin May-Davis, M.D.

Signature: _____ Date: _____

It is a federal requirement that each patient sign this form to begin/ continue treatment. Please sign before your next appointment.

Signature: _____ Date: _____

Print Name: _____