**Mark W. Wilson, MD**

**Executive Medical Director**

**Center for Wise Mind Living**

**Wise Mind Living Psychiatry**

**250 W54th Street, Suite 406**

**New York, New York 10019**

**(917) 566-5798 - office**

**(917) 621-6615 - emergency**

**(646) 514-5633 - fax**

mark@markwwilsonmdpc.com

assistant@markwwilsonmdpc.com

**General Billing/Insurance Information**

* **You can send in payment in the following ways**
	+ You may use **Zelle** (<https://www.zellepay.com/>) for payment, linked to **mark@markwwilsonmdpc.com****; make sure you type TWO w’s, not one**. It is also linked to (917) 621-6615.
	+ You may use **PayPal** ([paypal.me/markwwilsonmdpc](https://www.paypal.com/paypalme/my/profile)); **make sure you type TWO w’s, not one; it’s linked to my email mark@markwwilsonmdpc.com.**
	+ **You can give my assistant credit card information**.
	+ **You can send payment in by check to my office address above.**
* **Fees below full fee will be increased by ~2-5% annually at the start of the year, never to exceed full fee.**
* **I do not take any insurance, so payment of the bill is independent of and not contingent on the timing of and/or extent of possible insurance reimbursement.**
* **For out-of-network reimbursement by insurance**
	+ **Make certain your insurance company has my Tax ID Number (26-2982463**, Mark W. Wilson, MD PC).
	+ **Once you complete your portion of the CMS 1500 insurance reimbursement form, you must submit the form to insurance yourself, after making and keeping a copy for your records.**
		- In most cases, I have only completed my portion of the form; make sure every item in the form is completed with your information for your portion.
		- Sign items 12; leave item 13 blank.
		- Diagnostic codes are listed under 21 (A-L); it is then “coded” in 24 E (as, for example, “A” or “AB”). Despite the CMS form explaining how I am to complete the form, insurance will often inaccurately claim I did not list the diagnosis.
		- Complete item 29 if not already completed.
		- You do not need to return the bill/insurance form to me with your payment; make sure to send the form to insurance if you are seeking reimbursement.
		- Make sure your insurance company knows to send reimbursement directly to you and not to me; I must return and insurance payments sent to me back to your insurance.
* **For all patients, I may at times require in-person visits for in-person clinical assessments.**
* **For patients taking controlled substances, new Federal regulations beginning in 2025 will necessitate the following:**
	+ **Patients who reside in NY or** **NJ** andwho are taking controlled substances:
		- **I am required by law to see** **you in-person a minimum of one time per year**. I can see you virtually OR in-person all other times.
		- **For all ADULT patients receiving controlled substances, I will have to see you virtually OR in-person a minimum of three times-a-year**; under certain circumstances I can allow for a 15 minute appointment, rather than a 30 or 45 minute appointment.
		- **For all CHILD/ADOLESCENT patients receiving controlled substances, I will have to see you virtually OR in-person a minimum of four times-a-year**; under certain circumstances I can allow for a 15 minute appointment, rather than a 30 or 45 minute appointment.
	+ **Patients who do NOT reside in NY or NJ** and who are taking controlled substances:
		- **Except for vacations or in some cases college/graduate school, I will not be able to prescribe controlled medications outside of NY and NJ as of 10/1/2023 per Federal law**. I will only be able to continue medical care if you are physically in NY or NJ at the time of the appointment, and prescriptions will only be able to be sent to pharmacies in NY or NJ.
* **For patients taking non-controlled substances:**
	+ **I will only be allowed to prescribe medications for patients living in NY, NJ, CT, FL, and CA as of 1/1/2025 per Federal law.**
	+ **If you do not live in** **NY, NJ, CT, FL, or CA**, I will only be able to prescribe for you if you see me while you are located in one of the above states, and I will only be able to prescribe medications in one of those states.
	+ **When patients who live in NY, NJ, CT, FL, and CA are traveling (short term) to any of the remaining 45 states, I am able to prescribe non-controlled substances, as long as the individual state law allows it.** In most cases I can also prescribe to the remaining 45 states in the setting of college/graduate school.
* **For patients on Medicaid**
	+ **As I understand it, the laws with respect to Medicaid have changed, so that either some or all Medicaid plans require a doctor opted in to Medicaid coverage to prescribe medications or labs or both. As I am not opted in to Medicaid, that may mean that your insurance will not cover medications that I prescribe or labs that I order.** In this circumstance, we will either need to find you a Medicaid-accepting psychiatrist or a Medicaid-accepting medical provider willing to collaborate with me—in that scenario, I would function solely as a consultant, and the Medicaid-accepting medical provider would function as the prescribing and lab-ordering physician.
* **Reminders**
	+ **Always request refills from me directly, even if you’ve already notified your pharmacy.**
	+ **Always send me copies of insurance cards whenever insurance changes or a prior authorization is needed.**
	+ **Always request a new release of information sheet for any new clinician involved in your care.**
	+ **I do not accept Medicare; I am formally opted out.**
		- **As such, the law demands that you not submit my invoices for Medicare reimbursement for my services**
		- **We must have a written “contract” for the agreed upon fee for my services.**
	+ **If at any time you feel I made a billing error, please let my assistant Eric Scott Kincaid or me know, and we will make any necessary corrections immediately.**
	+ **Balances overdue for more than 60 days may be charged a monthly late fee of 5% of the total overdue balance, unless a payment plan is arranged with me.**
	+ **For those prescribed stimulant medications or Strattera (atomoxetine), please:**
		- **Buy an electronic wrist blood pressure/heart rate cuff** from either Amazon, Hammacher Schlemmer, Brookstone, or Sharper Image, and periodically let me know the measurements, especially during an appointment.
		- **Update me on current weight and height around the time of each appointment.**
	+ **There are inherent privacy risks associated with email communication. My email is business-level Gmail, which is only encrypted if the recipient also has business-level Gmail. If you do not wish to communicate via unencrypted email, contact me and we can use the encrypted MDOfficemail system, an encrypted portal, telephone, or you can come in person.**
	+ **If email communication is not clear or timely, contact me or my assistant by telephone.**
	+ At the start of each telehealth session, I will ask where you are located and whether you have full privacy for your telehealth session.
	+ With respect to letters for emotional support pets, I can write a letter stating you are in my care, your diagnosis, and that your pet provides you support (generally). I cannot say it’s a formal recommended medical accommodation or treatment.
	+ As a physician, I am committed to ensuring that my patients receive appropriate medical care and treatment. You can get information about your rights and how to report professional misconduct by visiting [www.health.ny.gov/professionals/doctors/conduct](http://r20.rs6.net/tn.jsp?f=001-ieUikVAAUxXFHQMVODHzTYK_YY_eaDzfcqJ4OCNDW8lt60VLzf6dauG8xk3ymzNBZBdv036kXhBoh-zMTOB-3ArASQnjrjKY8V6GeMjgg6zW3w0m1QaIFOwZS8Z0o0GDTaCm53eCIk16ptPEDek4cB0vAEcNxMOYbNOo2tePsME9jpfbmuKCmziN0GFEWYk&c=403N8VJPSxTgnKaetyHZpfs123CrWLApL4jb_lIISxGKUWQE87PF8w==&ch=Tg5p6tI4Wn0kdt9CFqBy9AXcjwikRq_ykq2nBDSZIamwIUZxjtI7CA==).
	+ The federal No Surprises Act takes effect on 1/1/2022; please see the “Fees and Billing” section of my website (<https://www.markwwilsonmdpc.net/fees-billing-and-insurance-info>) or request the info sheet from me for more details.

**The Federal “No Surprises Act”**

* The federal No Surprises Act takes effect on 1/1/2022. Under the law, healthcare providers need to give patients who don’t have insurance or who are not using insurance a Good Faith Estimate of the bill for medical items and services.
* You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This does not include any unknown or unexpected costs that arise during treatment. You could be charged more if complications or special circumstances occur.
* Make sure your healthcare provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item.
* You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
* If you are billed for more than the Good Faith Estimate of medical costs,
	+ You have a right to dispute the bill
	+ You can ask the provider for an updated bill to match the Good Faith Estimate
	+ You can ask to negotiate the bill
	+ You can ask if there is financial assistance available
	+ You have a right to initiate a patient-provider dispute resolution process with the US Department of Health and Human Services if the actual billed charges substantially exceed (by at least $400) the expected charges included in the Good Faith Estimate.
		- If you choose this route, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill
		- There is a $25 fee (paid to US Department of HHS) to use the dispute process
		- If the agency reviewing your dispute agrees with you, you will have to pay the price of the Good Faith Estimate
		- If the agency reviewing your dispute disagrees with you and agrees with the provider, you will have to pay the higher amount
* The initiation of a patient-provider dispute resolution process will not adversely affect the quality of healthcare services furnished to you.
* Make sure to save a copy or picture of your Good Faith Estimate.
* **For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 866-226-1819.**
* There may be additional items or services the provider may recommend as part of the course of care that must be scheduled or requested separately and are not reflected in the Good Faith Estimate. Upon request, the Good Faith Estimate can be updated.
* The information provided in the Good Faith Estimate is only an estimate; actual items, services, or charges may differ from the Good Faith Estimate.
* The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from the provider.

**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 form and 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 another provider.**

**Estimate of What You Will Be Charged**

**Patient name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Out-of-network provider(s) or facility name: Mark W. Wilson, MD, PC**

* 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**.
* **Total cost estimate of what you may be asked to pay: (see separate Good Faith Estimate)**
* **Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**
* **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):

\_\_ Mark W. Wilson, MDat Mark W. Wilson, MD, PC

* 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 will 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 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of patient Print name of guardian/authorized representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**