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

The No Surprises Act

- The 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(s) 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 to use the dispute process (charged by the US Department of HHS)
        - 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.

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

Good Faith Estimate of Services Offered

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 below)

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, MD at 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.

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

Good Faith Estimate of Services Offered

Patient name: _____

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

- **Diagnosis options for insurance purposes:**
  - **Adjustment disorder, unspecified (F43.20)**
  - **Anxiety disorder, unspecified (F41.9)**
  - **Depressive disorder, unspecified (F32.9)**
- **Please review my "Notice of Policies, Consent for Treatment, and Notice of Privacy/Confidentiality Rights"; in particular, with respect to late cancellations or missed appointments, please note:**
  - **Appointments cancelled less than one working day in advance will be charged (as below) for time reserved unless I am able to fill the time.**

- **Psychiatric evaluation/consultation**
  - Services
    - **Single 2-hour evaluation appointment**
      - CPT Code(s): 99205, 99214 (#4)
      - Date of Service:
      - Cost: **$1200**
    - **Two 1-hour evaluation appointments**
      - **First** 1-hour evaluation appointment
        - CPT Code(s): 99205, 99215 (#1)
        - Date of Service:
        - Cost: **$600**
      - **Second** 1-hour evaluation appointment
        - CPT Code(s): 99205, 99215 (#1)
        - Date of Service:
        - Cost: **$600**
      - **Total cost** for two 1-hour evaluation appointments: **$1200**
    - **Additional evaluation/consultation appointments needed for completion of evaluation**
      - CPT Code(s): 99205, 99215 (#1)
      - Date(s) of Service:
      - Cost: **$625/hour**
      - Anticipated cumulative total per period **(one year)**:
        - 0-2 hours: **0 - $1200**
- **Psychopharmacology/medication management follow-up appointments**
  - **15 min** appointment **(if/when clinically appropriate):**
    - CPT Code(s): 99213
    - Date(s) of Service:
    - Cost: **$315**
    - Anticipated cumulative total per period **(one year)**:
      - Adult patients
        - 0-12 times per year: **$0 - $3780/year**
      - Child patients
        - 0-12 times per year: **$0 - $3780/year**
  - **30 min** appointment
    - CPT Code(s): 99214
    - Date(s) of Service:
    - Cost: **$525**

        - Anticipated cumulative total per period **(one year)**:
            - Adult patients
                - 3-12 times per year: **$1575 - $6300/year**
            - Child patients
                - 4-12 times per year: **$2100 - $6300/year**
    - **45 min** appointment
        - CPT Code(s): 99215
        - Date(s) of Service:
        - Cost: **$575**
        - Anticipated cumulative total per period **(one year)**:
            - Adult patients
                - 0-12 times per year: **$0 - $6900/year**
            - Child patients
                - 0-12 times per year: **$0 - $6900/year**
    - **60 min** appointment
        - CPT Code(s): 99215, 99417 (#1)
        - Date of Service:
        - Cost: **$625**
        - Anticipated cumulative total per period **(one year)**:
            - 0-6 times per year**: $0 - $3600/year**
- **Parent collateral meetings, (separate from psychopharmacology appointments above)**
    - **30 min** appointment
        - CPT Code(s): 90846 or 90847
        - Date(s) of Service:
        - Cost: **$525**
        - Anticipated cumulative total per period **(one year)**:
            - 0-4 times per year: **$0 - $2100/year**
    - **45 min** appointment
        - CPT Code(s): 90846 or 90847
        - Date(s) of Service:
        - Cost: **$575**
        - Anticipated cumulative total per period **(one year)**:
            - 0-4 times per year: **$0 - $2300/year**
    - **60 min** appointment
        - CPT Code(s): 90846 or 90847
        - Date(s) of Service:
        - Cost: **$625**
        - Anticipated cumulative total per period **(one year)**:
            - 0-4 times per year: **$0 - $2500/year**
- **Other scheduled meetings (school/NY Department of Education/Court), forensic/legal/insurance/other paperwork, including transportation, when relevant**
    - **30 min** appointment or time
        - CPT Code(s):
        - Date(s) of Service:
        - Cost: **$525**
        - Anticipated cumulative total per period **(one year)**:
            - 0-3 times per year: **$0 - $1575**
    - **45 min** appointment or time
        - CPT Code(s):
        - Date(s) of Service:
        - Cost: **$575**
        - Anticipated cumulative total per period **(one year)**:
            - 0-3 times per year: **$0 - $1725**
    - **60 min** appointment or time
        - CPT Code(s):
        - Date(s) of Service:
        - Cost: **$625**
        - Anticipated cumulative total per period **(one year)**:
            - 0-3 times per year: **$0 - $1875**

- **> 60 min** appointment or time
    - CPT Code(s):
    - Date(s) of Service:
    - Cost: **$625/hour**
    - Anticipated cumulative total per period **(one year)**:

I understand the Good Faith Estimate

_____ _____

Signature of Patient/Caregiver of Patient <18 yo Date

Mark W. Wilson, MD
NPI: 1285632794
TIN: 26-2982463