Self-Pay Agreement Policy

I am signing this agreement to indicate that I am seeking mental health treatment from an OON )out-of-network) provider and to attest that I understand my treatment, starting on (DATE AGREEMENT SIGNED), will not be covered by insurance because:

I have no health insurance coverage/I am not aware of any insurance coverage for the services I am seeking. If it turns out on a later date that I did have coverage. I waive any future right to be reimbursed by my insurance plan for services that have already been provided.

 I am currently covered by insurance, but I am choosing not to use the coverage for my treatment. In doing so I understand that my provider will not be billing the insurance plan. I understand that in doing so, I waive any future right to be reimbursed by my insurance plan for services that already have been provided. I also understand that I may qualify for low or no-cost services by seeing a therapist that accepts my insurance.

I have been notified by my healthcare and/or insurance or workplace that my therapy/mental health counseling will not be covered by my plan because:

 It is not a covered benefit under my benefit plan.

 It is not covered by my plan because it does not meet the plan’s medical necessity.

 My benefits for this service have been exhausted or terminated.

I agree that the provider will collect charges for the therapy services at the rates outlined below:

SELF-PAY RATE

90791 Initial Evaluation $175
90837, 90847, 90846 Individual Therapy in person or video $160 (53+min)

Other service fees such as letters, medical records, court, etc. are included in the informed consent policy agreement. Any services with costs with be outlined in a good faith estimate in which you will be provided.

I understand that in signing this I waive any future right to be reimbursed by my insurance plan for services that have already been provided.

I understand that the payment is due in full at the time of service via cash, credit card or check.

I understand if I choose to use my credit card for payment, my card will be kept securely and charged immediately after session, unless indicated differently in credit card authorization.

DISCLAIMER

Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

**GOOD FAITH ESTIMATE**

*Pursuant to the No Surprises Act (HR133, Title 45 Section 149.610), this form is used to provide a current or prospective client with a “Good Faith Estimate” (GFE) of expected charges for services to be provided. This template is a hybrid of the ones recommended by several therapist professional associations.*

|  |  |
| --- | --- |
| Client Name:  | Client Date of Birth: |
| Client Address:  |
| Client Phone #: ( )  | Client Email: |
| Diagnosis Codes (if known): |
| Services Requested (Type and Codes):  |

|  |  |
| --- | --- |
| Provider Name  | License #: |
| Provider Address: |
| Provider Phone #: ( ) |
| Provider Tax ID# (if applicable):   | Provider NPI # (if applicable): |

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services that may be recommended during treatment to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for 90837, 9084, 908467 psychotherapy visit (in person or via telehealth) is $160, Intake 90791 is $175. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based on this per visit fee cited above, the following are expected charges of psychotherapy services:

Intake session 90791 $175, is a one-time occurrence at the beginning of therapy.

|  |  |  |
| --- | --- | --- |
| Number of Weeks | Total estimated charges for 1 session per week | Total estimated charges for 2 sessions per week |
| 1 Week of Service | $ 160 | $320 |
| 13 Weeks of Service (Approx. 3 Months) | $2080 | $4160 |
| 26 Weeks of Service (Approx. 6 months) | $4160 | $8320 |
| 39 Weeks of Service (Approx. 9 months) | $6240 | $12480 |
| 52 Weeks of Service (Approx. 12 Months) | $8320 | $16640 |

You have a right to dispute a bill if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). Initiating the dispute process will not adversely affect the quality of services rendered to you. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, 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. 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, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate 1/1/2022

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

(Client or Legal Guardian)

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_