Scottsville Counseling Center
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Good Faith Estimate for Health Care Items and Services

Patient			
Client Full Name:		Date of Birth:____/___/_____	
Street or PO Box			
City	State Zip Code		
Phone			
Primary Diagnosis (if applicable; to be completed by therapist) _____ Diagnosis code: _____			
Secondary Diagnosis (if applicable; to be completed by therapist) _____ Diagnosis code: _____ ***Section below to be completed by therapist after discussion with client.*			
Date(s) of Service	Description	Service Code	Estimated amount to be paid at time of service
	Initial 90-minute intake session (for couples and families where more than 1 individual is present)		$95.00 per 80-minute session
	Weekly sessions of 50 minutes for one full year (52 weeks)		$70.00 per 50-minute session
Total estimate of what you may owe			$3,665.00
Provider signature:		Date:	
NPI or EIN (if applicable)			

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan. Your therapist can provide referral options if you decide to use an in-network provider at any time and/or request to discontinue due to finances.

****Please Note:** many clients find there are ready to graduate and complete their work within a range of 12 to 20 sessions. Clients often begin meeting weekly initially to lessen the crisis that brought them to therapy. From there, clients typically transition from weekly to biweekly. As work continues forward, the client will move towards graduation, which is a completion of services with the therapist,

or continue meeting with a therapist to maintain their progress with a scheduling frequency ranging from every 3 to 8 weeks or as needed. Thus, the total listed above is estimated. Payments are not due ahead of time as clients are charged at time of session and for that session only.

Our practice is built upon the value of collaboration with our clients being an active partner with us in creating a path forward that is transparent, comfortable, and flexible to change as needed. This means as you move forward in your work, you and your therapist will update this Good Faith Estimate to reflect any changes in your anticipated number and frequency of sessions so that you are accurately and transparently informed of estimated costs.

The diagnosis section of the form above is required under the No Surprises Act to meet federal requirements. To ensure we support a tailored, confidential, collaborative process with you, our client, we will utilize the following information for the Good Faith Estimate diagnosis sections of this form and will ensure to explore with you any needed updates during sessions where a new Good Faith Estimate is provided.

Primary Diagnosis: Z73.3: Stress not elsewhere specified
Secondary Diagnosis: We will list/use as needed in collaboration with you.

This estimate reflects only mental health related therapy sessions. Additional offerings, such as workshops, yoga and meditation classes, etc. are outside the scope of this Good Faith Estimate.

If a client no shows and/or late cancels 2 times in a consecutive period, the therapist will explore options to assist the client in attending sessions and/or may proceed with discharging the client after discussing referral options that offer greater benefit to the client. This is done to honor what best supports the client in their journey and ensure no continued charges are made for missed and/or late cancelled sessions.

Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted 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 you receive a bill that is at least $400 more than your Good Faith Estimate, you have the right to dispute the bill with your provider or by visiting www.cms.gov/nosurprisesact. Additionally, this is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above

_____ _____

Client Name Client or Guardian's Signature

Date _____