**Davis Counseling & Play Therapy Center, PLLC**

**“Good Faith Estimate for Health Care Items and Services”**

**Under the No Surprises Act, Effective January 1, 2022 [H.R. 133]**

**Consent, Notice, & Good Faith Estimate**

**IMPORTANT:** The information provided in this document is to inform and notify individuals who are not enrolled in a health care plan or covered by a health care insurance company (e.g., uninsured individuals), or a Federal health care program, or individuals who are enrolled but not seeking to file a claim with their health care plan or coverage (self-pay individuals) of the expected and estimated charges they may be billed for receiving certain counseling services at Davis Counseling & Play Therapy Center, PLLC.

**I. CONSENT:** Davis Counseling & Play Therapy Center, PLLC does not accept health care insurance and is considered out-of-network for individuals who are insured under their health care insurance plans. Therefore, potentially resulting in some or all of the amounts paid for counseling services not counting towards your current health care plan’s deductible or out-of-pocket limit. All services provided by Davis Counseling & Play Therapy Center, PLLC are billed as self-pay only.

\_\_\_\_\_\_\_\_\_\_\_(initials) I understand that I am choosing to receive out-of-network counseling services at Davis Counseling & Play Therapy Center, PLLC knowing that services rendered would not be covered under my health care insurance plan (if insured).

\_\_\_\_\_\_\_\_\_\_\_(initials) I understand that I am choosing not to participate or receive counseling services from an in-network provider (if insured) at this time by receiving out-of-network counseling services at Davis Counseling & Play Therapy Center, PLLC.

\_\_\_\_\_\_\_\_\_\_\_(initials) Should I decide to participate or receive counseling services from an in-network provider (if insured), I will inform my counselor/provider, Suzanne Davis, LPC, RPT-S, where a list of in-network providers for counseling services will be provided.

Upon your request, a “superbill” (i.e., a form needed for you to file a claim with your insurance company for possible reimbursement) will be provided to you; however, you are responsible for filing the claim with your insurance company, and coverage for counseling services varies according to an individual’s plan and the insurance company. If you are considering a superbill, please contact your insurance company before counseling services are provided in order to understand if superbills are accepted under your health care insurance policy.

**Please Note:** The counselor rendering counseling services is out-of-network for insured individuals, and superbills may potentially be denied for reimbursement.

**II. NOTICE of “Right to Receive a Good Faith Estimate of Expected Charges”:**

**You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost.**

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an 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 includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
* Make sure your health care 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 health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
* If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
* 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 1-800-985-3059.

**III. GOOD FAITH ESTIMATE:**

**A. CLIENT INFORATION:**

Printed Name of Client:

 First Middle Last

Client Date of Birth: / /

Client Identification Number (if applicable):

Printed Name of Parent/Legal Guardian (if client is a minor):

 First Middle Last

Mailing Address (Street or PO Box, City, State, ZIP Code):

Phone Number: ( )

Email Address:

Please indicate your preferred method of contact: [ ] By mail [ ] By email

**B. CLIENT DIAGNOSIS:**

(To be completed by counselor rendering counseling services.)

Primary Service or Item Requested/Scheduled: Outpatient counseling services

\*Client’s Primary Diagnosis:

 Primary Diagnosis Code:

\*Client’s Secondary Diagnosis:

Secondary Diagnosis Code:

\* **Note to Client**: If you are a new client and have not received an intake session for counseling services at Davis Counseling & Play Therapy Center, PLLC, then a TBD will be indicated on this form due to needing further information and assessment before a diagnosis and diagnosis code can be determined. For current clients, your most recent diagnosis and diagnosis code on file will be provided on this document to reflect your current counseling needs and treatment goals as identified by the following, but not limited to: a prior diagnosis given by a medical professional, or a previous history of a diagnosis that has been provided to the client, or the client has received psychological testing by a psychologist to confirm a specific diagnosis.

If scheduled, list the date(s) the primary service or item will be provided:

[ ] Check this box if this service or item is not yet scheduled.

 Date of Good Faith Estimate: / /

Suzanne Davis, LPC, RPT-S $11,300-$11,400

Counselor/Provider Name Estimated Total Cost ((annual) as indicated on pages 4-5)

The following is a detailed list of expected and estimated charges/fees for outpatient counseling services at Davis Counseling & Play Therapy Center, PLLC. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

**C. COUNSELOR/PROVIDER INFORMATION:**

Counselor/Provider (Contact Person): Suzanne Davis, LPC, RPT-S

Practice Name: Davis Counseling & Play Therapy Center, PLLC

\*Practice Address/Location of Services:1365 South Military Highway, Suite 102, Chesapeake, Virginia 23320

Phone (Office): 757-533-2266

Email: sdavis@daviscounselingandplaytherapy.hush.com

National Provider Identifier (NPI): 1568886703

Tax Identification Number (EIN): 84-2222224

\***Please Note:** All counseling services (in-office counseling sessions and optional telehealth) are provided at the above practice address/location.

**D. DETAILS OF SERVICES AND ITEMS FOR DAVIS COUNSELING & PLAY THERAPY CENTER, PLLC:**

Included below is a Good Faith Estimate of potential counseling services rendered for one year (12 months or 52 weeks, not including holidays, vacations, etc.) should counseling sessions occur at the current full flat fee. **The final cost of services may be significantly different than the estimate, and the estimate shows the full estimated costs of services listed.** \*\***The estimated total for counseling services as provided does not reflect the sliding pay fee scale option should it be implemented.** Additionally, it does not include any information about what your health care plan may or may not cover. Contact your health care plan or health care coverage plan to find out if your health care plan under your health care insurance will pay any portion of these costs (e.g., “superbill”), and how much you may have to pay out-of-pocket.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service/Item (Description)** | **Service Code** | **Time** | **Quantity/****Frequency\*** | **Per Session Fee\*\*** | **Estimated Total (for 12 months or 52 weeks)** |
| Initial evaluation for counseling services/Intake session | 90791 | 60-120 minutes  | 1-2x annually | $100 | $100-$200 |
| 60-minutes counseling session (includes individual counseling sessions for child/adolescent/adults)/Telehealth 60-minutes counseling session  | 90837/90837-GT (95) | 50-60 minutes  | Weekly for 52 weeks | $100 | $100x52 = $5,200 |
| Family session without patient (includes individual and/or joint parent sessions/co-parenting for minor clients)/ Telehealth family session without patient | 90846/90846-GT (95) | 60 minutes  | Monthly | $100 | $100x12 = $1,200 |
| Family session with patient/Family session | 90847 | 60-75 minutes  | Monthly | $100 | $100x12 = $1,200 |
| Marital/Couples counseling | 90847 | 60-75 minutes  | 2x monthly | $150 | $150x24= $3,600 |
|  |  |  | Estimated Total Cost (annual): |  | $11,300-$11,400 |

\* At Davis Counseling & Play Therapy Center, PLLC, we recognize and understand that every client’s counseling journey is unique and different resulting in changes to the duration, frequency, and type of counseling services provided depending on the client’s counseling and treatment needs. Therefore, the quantity/frequency of counseling services noted in the Good Faith Estimate is an estimate rather than reflecting the actual number of sessions noted due to the individual counseling needs and treatment goals of the client.

How long and how often counseling services may occur can potentially be influenced by multiple factors including, but not limited to:

* Your identified treatment goals and counseling needs.
* Your schedule and life circumstances.
* Ongoing life challenges and/or situations.
* Counselor availability.

Additionally, you and your counselor will continually assess and evaluate the appropriate frequency of counseling services on an ongoing basis throughout your counseling journey to determine when you have met your treatment goals and are ready for discharge.

\*\*Davis Counseling & Play Therapy Center, PLLC, offers a sliding pay fee scale option, on a case-by-case basis for those experiencing economic and financial hardship where an agreed upon reduced rate will be established based on the family (household) income as noted below:

|  |  |  |
| --- | --- | --- |
| **Family (Household) Income Per Year** | **Per Session Fee****(Individual/Parent/Family Session)** | **Per Session Fee (Marital/Couples Session)** |
| Less than $25,000 per year | $50 | $75 |
| $25,000 to $50,000 per year | $75 | $100 |

Therefore, the Good Faith Estimate will be impacted based on the established frequency of counseling sessions, and/or if the sliding pay fee scale option is implemented at the current reduced rates noted above.

**IV. ADDITIONAL FEES:\***

Davis Counseling & Play Therapy Center, PLLC has the following additional fees that may incur throughout the duration of counseling services that may occur due to the following, but are not limited to:

* Insufficient-funds checks will be returned upon full payment of the original amount + $25 for any returned check
* Phone calls over 10 minutes in length will incur charges per the hourly rate ($100) in quarter hours:
	+ 15 minutes = $25
	+ 30 minutes = $50
	+ 45 minutes = $75
	+ 60 minutes = $100
* Requested letters to professionals (e.g., school related) and/or collaboration and coordination with necessary professionals (with your written permission/consent) for continuity of care purposes = $50 per requested letter
* Should you (or your attorney, or another party’s attorney, or your child’s attorney/GAL) request a copy of your or your child’s medical records, the cost is $1.00 per page.
* “No shows” and “late cancellations” are cancellations not made within the 24 hours prior to the scheduled appointment will incur a $50 no show/late cancellation fee.
* Medical records summary: Upon your request, the medical records can be summarized in lieu of releasing your or your child’s medical records, the cost will be $100 for a medical records summary.
* If the counselor is requested by you or your attorney or your child’s attorney/GAL, you will be responsible for paying a $2,500 fee prior to any court appearance.

\***Please Note:** The additional fees above are not included/calculated in the estimated total for counseling services as noted in the Good Faith Estimate, and not all additional fees will be rendered during the duration of counseling services.

**The counselor reserves the right to change any or all fees listed on this document, but will inform you and provide you with a revised Good Faith Estimate should fees change before the 12 months expiration date.**

**All fees and services listed and identified in this document are outlined in the Therapy Consent, Policies & Agreement.**

**V. 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.

**If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.**

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 and agrees with the health care provider or facility, 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 1-800-985-3059.

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059.

**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.**

**By signing below, you are acknowledging that you have read and understand the terms and conditions provided herein, including the “Notice of Right to Receive a Good Faith Estimate of Expected Charges” and the “Good Faith Estimate” of counseling services at Davis Counseling & Play Therapy Center, PLLC.**

Client Name (Printed)

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Client Signature Date

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

Parent/Legal Guardian Signature (if applicable) Date

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

Printed Name of Parent/Legal Guardian (if applicable)

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

Counselor (Printed/Signature) Date