Therapy Services Texas, LLC

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Fort Worth, TX 76107
(817) 690-5196
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No Surprises Act / Good Faith Estimate

No Surprise Act (NSA) was designed to reduce surprise billing from out-of-network providers, allows for fee transparency via a Good Faith Estimate (GFE), and allows for payment disputes (if quoted fee and actual fee is greater than $400). GFE is a notification of expected charges for scheduled or requested items or services-including items or services that are reasonably expected as a part of treatment. Remember: treatment will develop over time. The therapist and client work together to determine what best fits the client and their needs. Every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including: schedule and life circumstances, therapist availability, ongoing life challenges, the nature of specific challenges and how they are addressed, and personal finances.

Private Pay Agreement

Client Full Name: _____

Client Date of Birth: _____

Rates:

Service	Individual Counseling Fee	Couples Counseling Fee
Initial Intake and Assessment	$150.00	$175.00
Regular Telephone Sessions:		
45 minutes	$135.00	$150.00
1 hour, 15 minutes	$165.00	$190.00
1 hour, 30 minutes	$200.00	$225.00

The number of total sessions in the treatment is unknown at the outset and is based on the patient's needs, preferences, and progress made in the treatment.

I will be:

Paying out-of-pocket for my services

Note: Complete the remainder of this form if you, the client, will be paying out of pocket for services.

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The reason that I will not be using insurance to cover my treatment:

- ☐ I have no insurance/I am not aware of any insurance coverage for the services I am seeking. If it turns out at a later date that I did have coverage, I waive any present or 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 this coverage for my treatment. In doing so, I understand that my provider will not bill insurance or provide a Super Bill. I understand that in doing so I waive any present or future right to be reimbursed by my insurance plan for services that have already been provided.

I have chosen to begin and/or continue treatment with my provider on a self-pay basis starting the date of this form. I agree that the provider may collect charges for the treatment services at the provider's rate.

Initial: _____

I understand that I have the right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has already been taken in reliance theron.

Initial: _____

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

Initial: _____

I attest that I am seeking treatment with Therapy Services Texas, LLC, and will not be using insurance to cover my treatment sessions.

Initial: _____

My signature here indicates that I understand and consent to sharing the information provided above.

Signature: _____ Date: _____

For questions or more information about your right to a Good Faith Estimate, 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 a picture of it.
You may need it if you are billed a higher amount.