Questionnaire

** indicates a required field*

Enedina Robles, LCSW 25993, PMH-C
1300 East Shaw Ave Ste 171
Fresno, CA 93710
Office: 559-288-3164
Fax: 559-473-4731
NPI 1417270109
Tax ID 83-2428512

*** Client Full Name:**

*** DOB**

*** Home address:**

*** Phone Number:**

*** Insured Name (if different):**

PRIVATE PAY AGREEMENT

You understand that ENEDINA ROBLES, LCSW is accepting you/your insured as a private pay psychotherapy client beginning the date that this consent form is signed, and you will be financially responsible for any services that you/your insured receive, including cancelation fees.

You have elected to pay out of pocket for all services and do not wish for my psychotherapist, ENEDINA ROBLES, LCSW, to file a claim to your insurance carrier, now or in the future, if you have insurance.

You understand that you cannot retroactively seek monetary compensation for payments made, not now, nor in the future, in order to satisfy any deductible or out-of-pocket amount you may be subject to under the rules of your health insurance plan as a result of your decision to not initially use my insurance and/or gained insurance and did not inform your therapist.

You understand that payment, is due in full at the time of service or the agreement is void.

This GOOD FAITH ESTIMATE explains 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. 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. 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

As per Enedina's Practice Policies, regardless of diagnoses or length of services, the standard fees for in-person rendered at the address above, and telebehavioral health therapy services are as follows:

Initial intake session consisting of 75 minutes is $170.00
60 minute session is $150.00
45 minute session is $115.00
50 minute couples/family session is $150.00
30 minute session is $75.00
15 minute documentation fee is $25
Group fees are $45 for the 1.5 hour session
Late canceled or No Show appt fee is not $75
Court fees are documented in the Practice Policies

Your annual estimated costs for services will vary based on frequency of sessions, length of time in treatment, and commitment to treatment. Annual costs can vary for example from a one-time intake session of $170, to biweekly one-hour sessions of $150 for 52 weeks $15,600. These estimates do not include fees for court appearances should they be required.

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 HHS at (800) 368-1019. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (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.

* **Insurance Opt-Out/Acknowledgement of No Insurance: By e-signing this section, you acknowledge that you don't have insurance or you are opting out of using your insurance. Your electronic signature has the full force and effect of a wet signature affixed by hand to a paper document. You consent to the Private Pay Agreement and Good Faith Estimate as documented above effective the start date of your treatment with Enedina Robles, LCSW.** _____

I consent to sharing information provided here.