Tree of Life Counseling Services, LLC

Good Faith Estimate

Date of Good Faith Estimate: _____

This estimate is for psychotherapy services through _____

Brief explanation of estimate for new clients: The estimate below is the range of costs that is likely for most new clients seeking services with Tree of Life Counseling Services, LLC. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, symptoms, and needs. It is common for clients to participate in anywhere from 26-52 sessions for a total cost of $2,590 - $6,360, depending on recommended frequency and length of sessions. Actual frequency of sessions and length of time in treatment varies greatly depending on a client's need, and I will always discuss my recommendations with you at the beginning and throughout the duration of treatment.

Brief explanation for continuing patients: The estimate below is the range of costs that I think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact Jessica Beal, MS, LMHC at (904)863-5657 or jessica@treeoflifecs.com.

Details of the Estimate: The following is a detailed list of expected charges for assessment and psychotherapy services scheduled for _____. **The amount below is only an estimate; it isn't an offer or contract for services.** This estimate shows the full estimated costs of the items or services listed. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I send you an updated Estimate.

Service	**Diagnosis Code** (once determined)	**Service code**	**Quantity** (# of sessions or units. Give number or range)	**Cost per unit**	**Expected cost**
Initial evaluation		90791	1	$120	$120
Psychotherapy		90834, 90837, 90846, 90847	26-52	$95-$120	$$2,470-$6,240
				Total estimated cost:	**$2,590-$6,360**

Client information:

Client name: DOB:

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to me when I did the estimate. 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 $400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill.

You may contact your therapist at the contact information listed above to let them know the billed charges are at least $400 higher than the GFE. You can ask them to update the bill to match the GFE, 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 through HHS to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. 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 CMS at 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 CMS at 1-800-985-3059 .

IMPORTANT: You don’t have to sign this form. If you don’t sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that’s in your health plan’s network.

Keep a copy of this Good Faith Estimate (GFE) in a safe place or take pictures of it. You may need it if you are billed more than $400 than the estimate provided above.

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law. I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.
- I may have to pay the full charges for these items and services, or have to pay additional out- of-network cost-sharing under my health plan.
- I was given a written notice that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

_____

Client Name

_____

Signature of Client

_____

Signature of Parent/Guardian (if client is a minor)

_____

Date