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GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS & SERVICES

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider in your health plan's network, which may cost you less.

You're getting this notice because this provider isn't in your health plan's network. This means the provider doesn't have an agreement with your plan.

Getting care from this provider could cost you more.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider, or another one.

Estimate of what you could pay

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. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Common ICD 10 Diagnostic codes billed for: F41.1 (Generalized anxiety disorder); F43.20 (Adjustment disorder, unspecified); F33.0/ F33.2 (Major depressive disorder); F34.1 (Dysthymic disorder); F43.10 (Post traumatic stress disorder, unspecified); F90.0/F90.2 (Attention-deficit disorder); Z63.0 (Problem in relationship with spouse or partner)

Common CPT Service codes billed for: 90834 (Psychotherapy, 45 minutes) or 90837 (Psychotherapy, 60 minutes)

Estimated amount to be billed per session: $200 - $225

Total cost estimate of what you may be asked to pay annual: Weekly: **$10,400 - $11,700**; Bi-weekly: **$5,200 - $5,850**

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. It 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 are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact Full Recovery Wellness Center 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) 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 (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, I give up my federal consumer protections and agree to pay more for out-of-network care. With my signature, I am saying that I agree to get the items or services from Rachel Korenblit LCSW LLC. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that I can end this agreement by notifying the provider or facility in writing before getting services.

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Client Printed Name | Clinician Printed Name

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Client Signature | Date | Clinician Signature | Date