**Conscious Healing Counseling**

**2705 Bunker Lake Blvd NW Suite 112 Andover MN**

**15243 Nowthen Blvd NW Ramsey MN**

**NPI: 1366944597 ENI: 47-5554919**

**GOOD FAITH ESTIMATE (GFE) and FEE DISCLOSURE**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GFE Valid for 12 consecutive Calendar months from Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Services Provided and Associated Fees (Circle one)** \*Please note CPT codes will only be used for the purpose of submitting reimbursement claims to your healthcare insurance provider at your request only\*

1. Individual Psychotherapy (50 mins) CPT 90837 =$ 165.00
2. Family or Couples Psychotherapy (50 Mins) CPT 90847= $ 165.00
3. Psychotherapy for Crisis (50mins) CPT 90839=$ 165.00
4. Sliding Fee scale \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Initial \_\_\_\_\_\_\_\_***

**Other Services and Fees** \*These Fees are not eligible for discounts or sliding scale and due to the nature of the unpredictable nature of each client’s needs will not be included in the GFE. This information serves as notice of additional fees you may incur based on your personal needs\*

1. Unscheduled/Ad-Hoc/Crisis/Parent Consultation Phone Calls > 10 mins= prorated @ $165.00/50 mins
2. Requested Documentation to Include Treatment Summary, Other Provider Consultation, Superbill, Other Written Letters =prorated @ $/100.00 for 50mins
3. No Call No Show to Scheduled Appointment $100 .00
4. Cancelled Appointment < 48 Hours $75.00

***Initial \_\_\_\_\_\_\_\_***

**Frequency and Duration of Treatment**

Depending on your treatment needs, services will be provided for a frequency of one of the following and may fluctuate throughout the duration of treatment:

1. Weekly
2. Bi-weekly
3. Monthly (reserved for clients who have met treatment goals as defined by both client and therapist)
4. As-needed maintenance (reserved for clients who have met treatment goals as defined by both client and therapist)

Therapy is an extremely personal experience tailored to the needs of the client and the presenting concerns. Due to the nature of this unpredictability and Conscious Healing Counseling’s commitment to meeting and catering to the needs of every client individually, determining duration of treatment is ethically impossible*. The industry standard of most Health Insurance companies is 12-15 sessions.* You and your therapist will continue to review progress and make personalized decisions regarding both the frequency and duration of treatment periodically. Per Consent, you can decide at any time to terminate services. Due to this, all GFE’s will be based on your current frequency over the course of a 12 month/52-week calendar year)

***Initial \_\_\_\_\_\_\_\_***

**Diagnoses Used** \*Please note Diagnostic codes provided here are generic and used to satisfy the requirements of the No Surprises Act. Per our verbal discussion and your signature verifying the review of consent you understand that Diagnoses will only be provided for the purposes of submitting reimbursement claims to your healthcare insurance provider at your request. Any other diagnoses will be discussed between client and therapist for the purpose of treatment planning and referrals to appropriate providers\*

|  |  |
| --- | --- |
| F43.21 Adjustment Disorder with Depressed Mood | F32.0/296.21 Major Depression |
| F43.22 Adjustment Disorder with Anxiety | F41.1/300.2 Generalized Anxiety Disorder |
| F43.23 Adjustment Disorder with Mixed Anxiety and Depressed Mood | F43.10/309.81 Posttraumatic Stress Disorder |
| Z71.9 Counseling, Unspecified | Z13.9 Encounter for behavioral health screening unspecified |

***Initial \_\_\_\_\_\_\_\_***

**Health Insurance Waiver**

As both verbally discussed and as indicated by your signature on the consent, you understand that by using these services, you understand you are waiving the usage of your insurance. You are, however, more than welcome to use your HSA/FSA accounts for payment. You are responsible for understanding your own insurance benefits to include the co-pays and deductibles coverages available to you by choosing to work with a mental health provider within your insurance company’s network. Those amounts may or may not be less than the fees you are agreeing to pay Conscious Healing Counseling. Your signature on this GFE indicates your waiver of insurance benefits and paying the out-of-pocket fees as listed above.

**Personal Cost Estimation**

1. Your current fee per session is $\_\_\_\_\_\_\_\_\_\_\_. You are currently scheduling sessions (circle one) weekly bi-weekly monthly. Based on a 52-week calendar year, your total estimated cost of treatment, not including holidays, breaks, and other unpredictable fees/services disclosed above, will be $\_\_\_\_\_\_\_\_\_\_.

\*In an effort to reduce paper waste, this form will be kept in your client confidential file. If you would like a copy for your records, please request\*

***Initial \_\_\_\_\_\_\_\_***

Client Signature:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 1 Standard Notice: “Right to Receive a Good Faith Estimate of Expected Charges” Under the No Surprises Act (For use by health care providers no later than January 1, 2022) Instructions Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a “Good Faith Estimate” of expected charges. This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a “Good Faith Estimate” to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the availability of a “Good Faith Estimate” must be prominently displayed on the convening provider’s and convening facility’s website and in the office and on-site where scheduling or questions about the cost of health care occur. To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of their rights to receive such a notice. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process. NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information. [Link to IFR when available.] Health care providers and facilities should not include these instructions with the documents given to patients. Paperwork Reduction Act Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or OMB Control Number [XXXX-XXXX] Expiration Date [MM/DD/YYYY] suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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