# Good Faith Estimate to Satisfy Law Requirments

** indicates a required field*

The No Surprises Act was designed to protect consumers from receiving unexpected medical bills. Consumers may go to a facility that is in-network with their insurance company, but receive services at that facility from an out-of-network provider. The consumer is then surprised by medical bills that their insurance doesn't cover, in some cases totaling thousands of dollars. Due to this No Suprise Act, Dr. Rachel Rowitt is required by law to present a Good Faith Estimate to all self-pay, uninsured and out-of-network clients whom she treats. The following is what the law requires presented in writing and orally during when scheduling the initial appointment. Please contact Dr. Rowitt at 954-263-9657 with any questions. This document will need to be signed prior to beginning therapy at Grace Counseling, Inc. with Dr. Rowitt.

### * What is your name and date of birth?

Full Name

Date of Birth

* **Dr. Rachel Rowitt will be treating me in the capacity of mental health therapist on a weekly basis using the techniques of cognitive behavioral therapy, certified addictions therapy or EMDR therapy depending on what my needs are. All sessions are 60 minutes in length at the rate of $150 per session. The estimated yearly amount based upon this frequency is $7800. I understand that this an estimate based upon weekly sessions and that frequency and duration of sessions may change throughout this year and will not exceed $400 above this estimate.**

I consent to sharing information provided here.

For services rendered the law requires that codes and services be known in this good faith estimate. Meeting in the office is the service code 11 and Telehealth is service code 02. Diagnostic evaluation CPT code is 90791 and ongoing therapy sessions is CPT code

90837. Dr. Rachel Rowitt has opted to keep her rate the same for all services listed above.

* **At times, clients will need to call therapist for coaching or crisis management. Due to this new law, all services will have to be documented and charged. For telephone services the CPT service code for 5-10 minutes is 99441 at the charge rate of $30 and CPT service code 99443 will be used for 11-20 minutes at the charge rate of $60. In this good faith estimate it is averaged that using the 20 minute phone consultation call weekly for one year will cost $3120. I understand that this cost will not exceed $400 above this estimate.** _____

I consent to sharing information provided here.

* **The Good Faith Estimate requires a diagnostic code to be presented at time of signing this document. Because Dr. Rowitt will need at least three sessions to assess mental health, addiction and mood disorders, she has chosen to use the Adjustment Disorder NOS, F43.20 as the initial diagnosis code for the Good Faith Estimate document. This diagnosis allows for change of remission or further diagnosis should symptoms not resolve.** _____

I consent to sharing information provided here.

The Good Faith Estimate requires that you be made aware of Dr. Rowitt's professional information. Dr. Rachel Rowitt's NPI number is 1790942134 and tax id is 300483832. Her office location is 5491 North University Drive Suite 202A Coral Springs, Fl. 33067.

Disclaimer:
The provider may recommend additional items or services as part of the treatment that are not reflected in the estimate. These would need to be scheduled separately. The information provided in the Good Faith Estimate is only an estimate, as actual items, services, or charges may differ. The client has the right to engage in a dispute resolution process if the actual costs of services significantly exceed those listed in the Good Faith Estimate. The Good Faith Estimate does not obligate or require the client to obtain any of the listed services from the provider.

* **I have read and completely understand the presentation of the Good Faith Estimate in response to not having insurance, not wanting to use my insurance or that Dr. Rachel Rowitt does not accept my insurance or out of network benefits.** _____

I consent to sharing information provided here.