Good Faith Estimate

(Date)

To avoid financial burden and billing surprises we provide the Good Faith Estimate to better inform clients of expected payment prior to beginning services. This estimate is intended for clients who are self-paying and not utilizing insurance. This estimate will be determined between Inner Works Counseling and the client prior to treatment services. This estimate will include an estimated session rate and an estimated time frame of treatment services.

This is not a contract. You are not obligated to complete the duration of this estimate. It is an estimated outline of expenses for services for the client. Please direct questions about the details of this form to Shelby Closson: LMHC at Inner Works Counseling. For questions about the No Surprises Act and the Good Faith Estimate visit cms.gov/nosurprises

At Inner Works Counseling, Shelby Closson: LMHC meets with clients on a weekly and bi-weekly basis. Estimates will reflect this timeframe. Therapeutic work is unique and subjective to every client and every issue. More or less sessions may be clinically recommended based on the needs of the client, than what could be estimated on this form. This form will be initially drafted for a period of 12 months unless otherwise amended by the therapeutic alliance between client and counselor. Please note that additional fees may be incurred for No Show/Late Cancellations at a rate of $65 per incident. This cannot be included in the initial estimate as the quantity is unknown. Fees for service are provided below:

Inner Works Counseling, Shelby Closson: LMHC — Mental Health Counseling Services
NPI: — EIN:

Service Type:	Billing Code	Cost per Unit	Quantity	Adjusted Cost
Intake	90791	$	1	
Psychotherapy	90837/90834	$		
No Show Fee		$65	Limited to 2	N/A

Client Name: _____ _____ D.O.B _____

Client Name: _____ D.O.B. _____
The estimate for the cost of counseling services for _____
is based on (Agreed amount per session), (frequency of sessions) for (estimated duration of treatment).
Total Estimated Cost: _____

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.
If you are billed for more than this Good Faith Estimate, you may 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.

The client signature below only indicates that the client has reviewed this Good Faith Estimate and verbally confirmed its contents with the provider, Shelby Closson; LMHC. This signature does not bind the client to a contract of payment. The client MUST review this form prior to beginning services.

_____

Inner Works Counseling
Glens Falls, NY
Innerworksny.com
(838)722-0781
July 2023

Client Signature: _____ _____ Date:_____

Confirmed by provider, Shelby Closs Date: _____