Hope Within Healing Counseling Services, PLLC
Jamie Shields, LPC, LCDC
www.jamieshieldslpc.com
jamie@jamieshieldslpc.com
800 Rockmead Dr. #113, Kingwood, TX 77339
832-348-3713

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

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 1-877-696-6775.

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act

Hope Within Healing Counseling Services, PLLC,

Jamie Shields, LPC, LCDC

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Good Faith Estimate for Health Care Items and Services

PATIENT INFORMATION

- Patient name: _____
- Date of birth: _____
- Address: _____
- Phone number: _____
- Email address: _____
- Patient's contact preference: _____

_____

PATIENT DIAGNOSIS

- Primary service or item requested: Psychotherapy
- Primary diagnosis:
- Primary diagnosis code:
- Secondary diagnosis:
- Secondary diagnosis code:

_____

DATES

If scheduled, list the date(s) the Primary Service or Item will be provided:

Date range: 01/05/22 – 12/31/22

GOOD FAITH ESTIMATE

Total estimated cost:

Patient responsibility $_____ x (26 or 52) weeks = _____ or _____

The following is a detailed list of expected charges for therapy sessions, if scheduled. The estimated costs are valid through 12/31/2022 from the date of the Good Faith Estimate.

PROVIDER INFORMATION

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NPI: 1497394670
EIN: 84-4244044

DETAILS OF SERVICES & ITEMS

Service: Psychotherapy

- CPT/Service Code: 90791 (Intake)
- Date of Service (if known):
- Units: 1
- Expected Cost Per Unit: $155
- Location: Office/Telehealth

Service: Psychotherapy

- CPT/Service Code: 90837 (53+ minute session)
- Date of Service (if known):
- Units: 1
- Expected Cost Per Unit: $140
- Location: Office/Telehealth

_____

Cancellation Fee

I require a 24-Hour cancellation notice for all appointments. Late cancellation or missed appointment fees are not billable to insurance. The fees are as follows:

- $140 for a missed therapy appointment

_____

TOTAL EXPECTED CHARGES FROM Hope Within Healing Counseling Services, PLLC

$_____

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.

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 more than this Good Faith Estimate, you 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.

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 1-877-696-6775.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

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.

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THE NO SURPRISES ACT: STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

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 or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

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

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

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. Contact your health plan for more information.

You shouldn't sign this form if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

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

This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

Signature of Acknowledgement and Receipt of the Good Faith Estimate Notice

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____