IglePsych, Inc. – Good Faith Estimate

Starting Date of Good Faith Estimate for Established Patients: 08/01/2024

Starting Date of Good Faith Estimate for New Patients: 05/01/2024

Brief explanation of estimate for new patients:

The initial evaluation fee for new patients is $400. Urgent evaluations outside of normal operating hours will incur a fee of $600. The list below is the range of costs for provided services. Follow-up treatment plans will be individualized.

Brief explanation for continuing patients:

The list below is the range of costs for provided services.

Contact: If you have questions about this estimate, please contact the front desk at 850-374-3990 or Frontdesk@iglepsych.com.

Details of the Estimate:

The following is a detailed list of charges for our services. This list is valid through August 2025, or until a new fee estimate is provided by the office.

Service:	Time:	Cost:
New Patient Appointment	60 minutes	$400
Urgent Evaluation (outside normal hours)	60 minutes	$600
Psychiatry Follow-up Appointment	20 minutes	$150
Psychiatry Follow-up Appointment	30 minutes	$200
Psychiatry Follow-up Appointment	40 minutes	$250
Psychiatry Follow-up Appointment	50 minutes	$300
Psychiatry Follow-up Appointment	60 minutes	$350
MMJ Initial Appointment – New Patient	60 minutes	$350
MMJ Initial Appointment – Established Patient	40 minutes	$300
MMJ Takeover – New Patient	40 minutes	$250
MMJ Takeover – Established Patient	40 minutes	$200
MMJ Recert Appointment	20 minutes	$200
MMJ/Meds Combo Appointment	40 minutes	$250
ADHD Evaluation – Established Patient	40 minutes	$300
Pharmacogenetics Testing Appointment	40 minutes	$300
ESA Letter – Non-Established Patient	40 minutes	$300
ESA Letter – Established Patient	N/A	$150
TMS Evaluation	40 minutes	$300
Shot Fee	N/A	$50

Ketamine Club ***20 minute appt every 3 months included as long as monthly ketamine payments are current**	monthly	$250

Psychiatrist providing services: Name James Igleburger M.D.

Address of office from which services will be provided:

14 Racetrack Road NW, Fort Walton Beach FL, 32547

Patient information:

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected to address your mental health care needs. It is impossible to know in advance what services a client will require. Please refer to the list of service charges.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged for more services if they are needed. The fees for all of our services are detailed in the above chart. You will NOT be charged for services until they are rendered. You will NOT be billed in excess of the listed fees. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for $400 more than this Good Faith Estimate (GFE), you have the right to dispute the bill.

You may contact IglePsych, Inc. at the contact listed above to let them know the billed charges are at least $400 higher than the GFE. You can ask them to update the bill to match the GFE, 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 GFE. 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 CMS at 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

This GFE is not a contract. It does not obligate you to accept the services listed above.

Keep a copy of this Good Faith Estimate (GFE) in a safe place or take pictures of it.

Patient name _____ DOB _____

Witness _____ Date_____