Good Faith Estimate

** indicates a required field*

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GOOD FAITH ESTIMATE (GFE) for Services 1/1/2022-12/31/2022 Provided by Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC.

Under Section 2799B-6 of the Public Health Service Act, healthcare providers and healthcare facilities are required to provide a Good Faith Estimate, both orally and in writing, of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a federal healthcare program, or are not seeking to file a claim with their plan or coverage upon request or at the time of scheduling healthcare items and services. 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 do not 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.

*You are receiving this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not have an agreement with your plan. THIS IS NOT A BILL

Client's Name:

Client's Date of Birth:

Client's Address:

Client's Phone Number & Email Address:

Client's Diagnosis: *Z65.9 Problem related to unspecific psychosocial circumstances
*This diagnosis is only to satisfy the federal requirement for this form. This is not your formal psychological diagnosis. A formal diagnosis can be provided after a full assessment has been conducted.

SERVICES & FEES

LOCATION OF SERVICES DELIVERED: Dianne Gottlieb, MS, LMFT, OF Scottsdale Therapy, PLLC, offers a telehealth-only practice.
The following is a list of services and their FULL fee. This does not consider any grandfathering fees that may be applied to your services at any time. Please note CPT codes will only be used for the purpose of submitting reimbursement claims to your healthcare insurance provider for out-of-network reimbursement at your request only. I cannot guarantee any reimbursement from insurance as I am not an insurance provider nor do I accept insurance.

Individual/Couple/Family Intake Session (50-55 mins) Telehealth CPT 90791-95 = $200
Individual Psychotherapy (50-55 mins) Telehealth CPT 90837-95 = $200
Individual Psychotherapy (30 mins) Telehealth CPT 90832-95 = $100
Individual Psychotherapy (85 minutes) Telehealth CPT 90837-95 + CPT 99354-95 = $300
Individual Psychotherapy (115 mins) Telehealth CPT 90837-95 + CPT 99354-95 = $400
Couple or Family Psychotherapy (50-55 mins) Telehealth CPT 90847-95 = $200
Couple or Family Psychotherapy (30 mins) Telehealth CPT 90847-95 = $100
Couple/Family Psychotherapy (85 minutes) Telehealth CPT 90847-95 = $300
Couple/Family Psychotherapy (115 minutes) Telehealth CPT 90847-95 = $400
Engaged Couple Premarital Counseling (4 session package of 50-55 min sessions) Telehealth CPT 90847-95 = $150/session x 4 sessions = $600
Cancellation Fee = Your therapist requires a 24-HOUR CANCELLATION FEE and FULL SESSION FEES APPLY FOR LATE CANCELLATIONS/NO CALL/NO EMAIL/NO SHOW to Scheduled Appointments (as defined in Informed Consent) . Exceptions made due to emergencies and illness. CANCELLED APPOINTMENT with AT LEAST 24-HOUR NOTICE = NO CHARGE.
Unscheduled/Ad-Hoc/Crisis/Consultation Phone Calls more than 15 minutes - Prorated at $200/50-55 mins

Requested Documentation to include but not limited to: Treatment Summary, Other Provider Consultation, Superbill, or Written Letters CPT 96101 = Prorated at $200/50-55 mins

FEE ESTIMATES

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 based on clinical needs; a.) Weekly, b.} Bi-Weekly, c.) Monthly (reserved for clients who have met treatment goals as definted by both client and therapist. d.) As needed (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 my 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. Together we will continue to review progress and make personalized decisions regarding both the frequency and duration of treatment. Per the Informed 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.

PERSONAL COST ESTIMATE: *THIS IS NOT A BILL*

Your current fee per session is $_____ . Your estimate will depend on if you choose to meet weekly, bi-weekly, monthly or as needed. Estimate can range from $_____ (once per calendar year) to $_____ (52 weekly sessions). You are currently scheduling sessions _____. Based on a 52 week calendar year, your total estimated cost of treatment, not including holidays, breaks, and other unpredictable fees/services, will be $_____.

Common Diagnoses Codes Used

Please note that 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 the Informed 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 diagnosis will be discussed between client and therapist for the purpose of treatment planning and referrals to appropriate providers.

F43.23 - Adjustment Disorder with Mixed Anxiety and Depressed Mood
F41.1 - Generalized Anxiety Disorder
F90.0 - ADHD, Predominantly Inattentive Presentation
F34.1 - Persistent Depressive Disorder
F64.1 - Gender Dysphoria in Adolescents and Adults
Z63.0 - Relational Problems with Spouse or Intimate Partner
Z62.820 - Parent-Child Relational Problem

HEALTH INSURANCE WAIVER

As both verbally discussed and as indicated by your signature on the Informed Consent, you understand that Dianne Gottieb, MS, LMFT, of Scottsdale Therapy, PLLC, does not accept insurance as a method of payment. 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 Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC. Your signature on this GFE indicates your waiver of insurance benefits and paying the out-of-pocket fees as listed above. At any time, you may request Out of Network Billing Statement(s) from Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy. This statement will include Dates of Service, Billing Codes, and Diagnostic Codes. You may choose to submit these statement(s) to your insurance company in an effort to request full or partial reimbursement. Your signature on this GFE indicates that the reimbursement decision is that solely of your insurance provider and Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC, in no way guarantees or has authority in this reimbursement decision.

THIS GOOD FAITH ESTIMATE IS VALID FOR 12 CONSECUTIVE MONTHS FROM THE SIGNATURE DATE

With my signature I am saying that I agree to receive services from Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC. With my signature I acknowledge that I am consenting on my own free will and am not being coerced or pressured. I also understand that I am giving up some consumer protections under federal law. I may receive a bill for the full charges for these items and services or have to pay out of network cost sharing under my health plan. I was provided with a written notice explaining that my provider or facility is not in my health plan's network. The estimated cost of services and what I may owe if I agree to be treated by this provider or facility. I received the notice on paper or electronically, consistent with my choices. I fully and completely understand that some or all amounts I pay might not count toward my health plans deductible or our of pocket limit. I can end this agreement by notifying the

provider or facility in writing before obtaining services. IMPORTANT: You DO NOT have to sign this form, but if you do not sign this form, this provider or facility may not treat you. You can choose to obtain care from a provider or facility in your health plan's network.

By signing below, I acknowledge I have received a Good Faith Estimate from Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC.

QUESTIONS ABOUT THIS GOOD FAITH ESTIMATE? Contact Dianne Gottlieb, MS, LMFT, of Scottsdale Therapy, PLLC, at 480/314-0055

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 HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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.