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**The No Surprise Act and Good Faith Estimates**

The No Surprise Act was established to help protect patients from unexpected medical bills and was passed in 2021. The Good Faith Estimate provision is part of the No Surprise Act and is meant to provide patients with an approximation of what you might pay while receiving a medical intervention.

Therapy is an insurance covered medical intervention and is difficult to judge how long it may take to address a person’s presenting difficulty. Some individuals may find only a few sessions are needed while others may find they need more sessions to cope and move forward. Others struggling with in-depth persistent struggles may need to undergo long-term therapy. It is difficult for the therapist to know, prior to the first session in which category the individual might fall into. The following tables provide you what your cost might be depending on the length of sessions and the amount of co-pay your insurance is requiring. The second table is for those patients paying full price, private pay.

Insurance- Co-Pay:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of sessions | At $0.00 a session | At $10.00 a session | At $20.00 a session | At $30.00 a session | At $40.00 a session |
| 5 | $0 | $50.00 | $100.00 | $150.00 | $200.00 |
| 10 | $0 | $100.00 | $200.00 | $300.00 | $400.00 |
| 15 | $0 | $150.00 | $300.00 | $450.00 | $600.00 |
| 20 | $0 | $200.00 | $400.00 | $600.00 | $800.00 |

\*Estimated payments by patient is paying a specific co-pay. This does not include (1) payment for additional non-covered services (2) payment for no-show charges which are $125 a time. \*\* This also does not include other insurance deductibles or other fees from insurance.

Private Full Pay:

|  |  |  |
| --- | --- | --- |
| Number of sessions | Intake session amount (1st session) | Sessions after the 1st session- $180.00 a session |
| 1 | $200.00 |  |
| 2 | 0 | $380.00 |
| 5 | 0 | $1,100.00 |
| 10 | 0 | $2,000.00 |
| 15 | 0 | $2,900.00 |
| 20 | 0 | $3,800.00 |

\*Estimated payments by patient paying full private pay. This does not include payment for additional services such as court fees or no-show charges ($125.00).

By your signature below, you are indicating that you have read and understand the statement, and there any questions you have about the same I have an answer to your satisfaction.

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Clients/Guardian’s Signature Print Name Date

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Counselor’s Signature Print Name Date