DISCLAIMER

This Good Faith Estimate is based on information known at the time the estimate was created. The information provided in this Good Faith Estimate is only an estimate of direct psychotherapy services and ***does not consider other potential costs****, including, but not limited to 1) late cancellation or no-show fees, 2) session hold fees, 3) time provided on phone calls or reading/writing emails greater than 10 minutes, 4) requests for letters, subpoenas, or any court/legal related costs.*

You have the right to enter a dispute resolution process if the actual cost of psychotherapy services billed is greater than $400 over the Good Faith Estimate, which is based on the known costs related to the agreed upon time in session. The Good Faith Estimate does not obligate or require you to obtain any of the listed services from this provider. Please save a copy of this completed document for your records.

IF YOU ARE BILLED FOR MORE THAN THIS GOOD FAITH ESTIMATE FOR DIRECT SERVICES, YOU HAVE THE RIGHT TO DISPUTE THE BILL.

You may contact the healthcare provider to let them know the billed charges are higher than the Good Faith Estimate. You can ask for 1) an itemization of the charges,2) the bill to be updated to match the Good Faith Estimate,3) ask to negotiate the bill, or 4) ask if there is financial assistance available.

You may also begin a dispute resolution process with the US 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 in the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with your position, you will have to pay the indicated amount on this Good Faith Estimate. If the agency disagrees with your position and agrees with the position of the health care provider, you will have to pay the higher amount billed to you by the provider.

To learn more or get a form to start the process, go to www.cms.gov/nosurprises or call HHS at 800-368-1019.

PROVIDER: LESLIE JOHANNES, LMFT

Signed by Provider September 9, 2024

CLIENT NAME(S): _____

I/We acknowledge being provided a Good Faith Estimate of the potential cost of direct psychotherapy services for a twelve-month period. The GFE provided was calculated as shown in the body of this document.

Signature_____ **Date** _____

Sgnature_____ **Date**_____

GOOD FAITH ESTIMATE for PSYCHOTHERAPY SERVICES

You are entitled to receive this Good Faith Estimate of what the charges may be for psychotherapy services provided to you. While it is not possible for a therapist to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend on 1) the number of therapy sessions you attend, 2) your individual circumstances, and 3) the type and frequency of services provided to you. This estimate is not a contract and does not obligate you to obtain any services from Leslie Johannes, MEd, LMFT, CST-T.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you will need to attend or be limited to a specified number of therapy sessions. The number of visits that are appropriate in your case, and the estimated cost of those services depends on your needs and what you agree to in consultation with Leslie Johannes, MEd, LMFT, CST-T. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue your treatment at any time. This estimate applies to both in-person and telehealth sessions.

PATIENT INFORMATION

Name 1 (first, middle, last): _____ DOB: _____

Name 2 (first, middle, last): _____ DOB: _____

Address (residence, street, city, state, ZIP): _____

Contact 1 (phone, email, circle preference): _____

Contact 2 (phone, email, circle preference): _____

Patient Diagnosis code
I am not able to ethically provide a diagnosis to a patient before meetings and completion of assessments. A general diagnosis is provided to satisfy the requirements of the Good Faith Estimate. I will use the following temporary codes: Z71.9 "Counseling unspecified" for individuals and Z63.0 "Problems in Relationship with Spouse or Partner" for couples. Following your diagnostic assessment (typically 3-5 sessions), your treatment plan and diagnosis code will reflect a more accurate representation of your diagnostic picture.

Note: A diagnosis does not change the estimated cost of service, as this is simply based on type of service fee (individual or relationship therapy), multiplied by the total number of sessions that may occur in a twelve-month period.

PROVIDER ESTIMATE FOR PSYCHOTHERAPY WITH LESLIE JOHANNES, MED, LMFT, CST-T
(Session fee X 46 weeks in a 12-month period = Total estimated cost of psychotherapy services)
a) $160 x 52 weeks = $8,320.00 **b) $160 x 26 once every other week = $4,160.00**

Leslie Johannes, MEd, LMFT, CST-T
4333 Fairwood Blvd NE, Tacoma, WA 98422
Contact person: Leslie Johannes (business owner)
Phone: 253-533-8141
Email: leslie@lesliejohannes.com
National Provider Identifier (NPI): 1316067259
Taxpayer Identification Number (TIN/EIN): 47-2958803

DETAILS OF SERVICES PROVIDED BY LESLIE JOHANNES, MED, LMFT, CST-T
Couple or Individual Psychotherapy
Telehealth provided from Leslie Johannes' home office via Doxy.me or Zoom
In-person services provided at: 4333 Fairwood Blvd NE, Tacoma, WA 98422
Diagnosis code [ICD 10]: Z71.9 (individual) and/or Z63.0 (couple)
Service code: 90834 or 90837
Quantity: **a)** once a week, up to 52 sessions **b)** once every other week, up to 26 sessions
Total Expected yearly charges from Leslie Johannes, Med, LMFT, CST-T = $8,320 (weekly) / $4,160 (biweekly)