

## **Revive Counseling**

### **Good Faith Estimate**

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a “Good Faith Estimate” (GFE) of expected charges. The GFE shows the costs of items and services that are reasonably expected for services provided by Revive Counseling. The estimate is based on information known at the time the estimate was created. It does not take into account any reimbursement that you may receive as a result of out-of-network benefits submitted directly by you.

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 you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)

**Counseling  
Good Faith Estimate  
Table of Services and Fees**

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	\$125
	90832	Psychotherapy, 30 minutes	\$60
	90834	Psychotherapy, 45 minutes	\$120
	90837	Psychotherapy 50-55 minutes ( <a href="#">This fee is my hourly rate &amp; used for all prorated calculations as indicated</a> )	\$125
	90846	Family Psychotherapy without Patient Present, 50 minutes	\$150
	90847	Family Psychotherapy with Patient Present, 50 minutes	\$150
	90853	Group Psychotherapy	\$50
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancellation Fee	Your Therapist Requires a 24-Hour Cancellation Notice-If you do not cancel or reschedule 24 hours before your scheduled appointment you will be charged half the session fee.	You are Responsible for half of the session fee of the appointment missed
	Production of Records	Requests for copies of file or individual notes	.25 per page
	Legal Fees	If this counselor is ever requested to go to court for a client	See attached form for breakdown of fees

	Total Estimate:	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.

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

I \_\_\_\_\_ have read and understand the listed fees above.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_