No Surprises Act

* *indicates a required field*

Good Faith Estimate for Health Care Items and Services

Expiration Date: 1 year from the date of signature

Client Information

*** Client**

*** First name:**

*** Middle initial:**

*** Last name:**

*** Date of birth:**

* Client Contact Information

* Street or PO box:

* City, state, ZIP:

* Phone number:

* Email address:

* Client's contact preference:

Client Diagnosis

Primary service or item requested/scheduled:

Client primary diagnosis (if applicable):

Client secondary diagnosis (if applicable):

If scheduled, list the date the Primary Service or Item will be provided:

* Date of good faith estimate(today's date):

*** Provider Estimates: The following is a detailed list of expected charges. The estimated costs are valid for 12 months, but you are entitled to receive an update on this estimate at any time upon request (Please select the service that you are receiving).**

- [ ] $110 Individual
- [ ] $160 Couple
- [ ] $195 Family

Provider Information

Provider name: A&P Counseling and Consulting, LLC
Provider/facility type: Mental Health Services via Telehealth
State: Louisiana, USA
Contact person: Semonne' Pierre, NCC, LPC-S
Phone: 504-517-5776
Email: sapierrecmhc@gmail.com
NPI Number:1508399007

Additional health care provider/facility notes:

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, and does not include any unknown or unexpected costs that may arise during treatment.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

Throughout your treatment, the provider may recommend additional items or services as part of your treatment that are not reflected in this estimate. These would need to be scheduled separately with your consent and the understanding that any additional service costs are in addition to the Good Faith Estimate.

If your needs change during treatment, your provider should supply a new, updated Good Faith Estimate to reflect the changes to treatment, and the accompanying cost changes.

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.

The Good Faith Estimate is not a contract between provider and client and does not obligate or require the client to obtain any of the listed services from the provider.

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) 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 (800) 985-3059.

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.

* Acknowledgement of The Good Faith Estimate

- [ ] By checking this box, I acknowledge that I have read and understand the Good Faith Estimate.