**Good Faith Estimate for Health Care Services**

Please note, this is not a pay agreement contact. This is an overview of the possible cost you may incur when working with a provider at Calm Counseling, LLC which is required by law so there are no surprises.

Calm Counseling, LLC

1424 NE 155th St., Suite 207

Shoreline, WA 98155

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NPI # 1760823884

Tax ID / EIN # 46-5346965

MFT License # LF60602121

This estimate covers both in-person and telehealth appointments. All therapists at Calm Counseling, LLC are covered by this Good Faith Estimate (GFE).

Today's Date

This Good Faith Estimate (GFE) is valid for 12 consecutive calendar months from date signed unless superseded by a more up to date document.

**Client #1 Information**

\* Client Name:

\* Client Last Name

\* Legal Name (If different from above)

\* Client Contact Information \*

Date of birth:

Street or PO box:

City, state, ZIP:

Phone number:

Email address:

Patient's contact preference:

**Client #2 Information**

\* Client Name:

\* Client Last Name

\* Legal Name (If different from above)

\* Client Contact Information \*

Date of birth:

Street or PO box:

City, state, ZIP:

Phone number:

Email address:

Patient's contact preference:

**Self-Pay & Sliding Scale Clients**

Self-Pay (full rate) clients are eligible for Invoices "Superbills" for out-of-network insurance reimbursement upon request.

*Note: Not all services are reimbursed by insurance companies including couples’ therapy. Please check your specific plan to see if couples therapy can be reimbursed. If not, all costs of services will be out of pocket.*

**Out-of-Network Insurance Information**

We **do not** hold a contractual relationship with insurance at this time and will not be able to provide any communication or documentation beyond requested Invoices/"Superbills" for reimbursement.

To facilitate being potentially reimbursed by your insurance company, we suggest you do the following:

1) Please contact your insurance company and verify that out-of-network mental health services will be covered under your plan and inquire about the exact dollar amount they will cover, as well as what your portion will be. Often, they will give you a percentage that is capped at a certain dollar amount, so it is best to know the maximum amount they will pay.

2) Ask if there are any limitations to the number of visits or session lengths that they will cover. It is ultimately your responsibility to secure reimbursement.

3) Ask if your insurance covers couples therapy as OON. If not, you will be responsible to cover these charges.

4) Communicate with Calm Counseling, LLC that you will need monthly Invoices/"Superbills" sent to you for submission to your insurance company.

**Out-of-Network Waiver**

***By using these services, you understand you are waiving the usage of your insurance for any plan***. 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.

Your in-network providers can be found on your insurance company's website. Those amounts may or may not be less than the fees you are agreeing to pay Calm Counseling, LLC.

*We do not accept reimbursement from out-of-network insurance companies. This reimbursement must go to the clients after payment at time of service*.

Your signature on this GFE indicates your waiver of insurance benefits and paying the out-of-pocket fees as listed above (or the agreed upon sliding scale rate before commencement of services).

If you are paying our full rate of $150 / 55-minute session or $225 / 90-minute session, you may, at any time, request Out of Network Billing statement(s) (a "Superbill) from Calm Counseling, LLC. This statement will include Dates of Service, Billing Codes, and Diagnostic Codes. You may choose to submit these statement(s) to your insurance company to request full or partial reimbursement.

Your signature on this GFE indicates that the reimbursement decision is that solely of your insurance provider. Calm Counseling, LLC in no way guarantees or has authority in this reimbursement decision.

**Payment Due at Time of Service**

All payments are due at the time of service. Calm Counseling accepts Venmo, Zelle, check and cash. We are also able to take credit cards and HSA/FSA cards at this time. Calm Counseling, LLC requires an active credit card on file for all clients and this card will be charged automatically the day of service for all applicable fees, including all unpaid fees for services or late cancellations.

Calm Counseling, LLC reserves the right to use legal means to secure payment beyond thirty (30) days past due, which may involve a collection agency or small claims court. If referred to collections, all interest and legal fees will also be the responsibility of the debtor/guarantor. Unless you have worked out a specific payment plan, balances that accrue without payment for thirty (30) days past the most recent date of service will be subject to a possible late charge. Non-payment of balances is a cause for termination of services at Calm Counseling, LLC.

* As discussed, and as indicated by your signature on this document, you understand that Calm Counseling, LLC does NOT accept insurance. You also understand that all payments (including late cancellations) are due at the time of service.

**Diagnosis and Diagnosis Codes**

We are not able to ethically provide a diagnosis to a client before meeting with them. Please note Diagnostic codes provided on this form are generic and used to satisfy the requirements of the No Surprises Act. Per our verbal discussion and your signature verifying the review of this document, you understand that Diagnoses will only be provided after meeting with you for at least 1-3 sessions and for the purposes of submitting reimbursement claims to your healthcare insurance provider and for clarity of treatment goals.

Diagnostic codes in psychotherapy do not impact reimbursement for services. For the purposes of this document, your diagnosis is V65.40 (Z71.9) "Other Counseling or Consultation" or Z63.0 Relationship Counseling. Any diagnosis or treatment plan provided by your clinician supersedes this generic diagnosis.

**Provider Estimate**

The following is a detailed list of expected charges. It is typical for therapists to raise their rates. You will be advised of rate changes with a 60-day notice and a new Good Faith Estimate form will be provided. The estimated costs are valid for 12 months from the date of the Good Faith Estimate unless a rate change occurs, and a new Good Faith Estimate is provided.

The current fee for a standard 55-minute intake or psychotherapy session individual session is $150 per session (including couples), unless you have a pre-arranged sliding scale fee.

Cancellation Fee (within the 24-hour window) - $150

There is NO charge for communication related to scheduling.

There is NO charge for a consultation call to see if we are a good fit therapeutically.

**Frequency and Duration of Treatment**

How long you stay in treatment is entirely up to you.

Every Client's journey is unique, and you can stop services at any point. How long and how frequently you engage in therapy is influenced by:

- Scheduling and life circumstance

- Ongoing Life Challenges

- The Nature of your Specific Mental Health Challenges and how you address them.

Many clients see their therapist 1x/week. You and your therapist will continually assess your need for therapy and make recommendations. You always have agency to discontinue treatment at your discretion. This GFE is based on our standard of care (1x/week).

By signing this document, you are acknowledging that it is possible that you will need more or less frequent therapy, dependent on your individual needs. These needs are assessed and agreed upon by both clinicians and clients. It is always your choice to engage in more frequent therapy than 1x/week.

By signing this document, you are acknowledging that any choice to have a frequency of more than 1x/week is made with an understanding that our session fee is $150, and you are responsible for covering that fee, regardless of mental health insurance coverage.

**Details of Services and Items for Calm Counseling, LLC:**

90791 – 55-minute Psychotherapy Assessment $150/Session (1-3 sessions)

90837 – 55-minute Psychotherapy, $150/Session

90847 – 55-minute Couples or Family Therapy $150/Session

99354 – Ind/Family/Couples with client additional 30-minutes $75/Session

**What is your payment status?**

[ ]  I have an Out-of-Network insurance plan and want to submit Invoices/"Superbills" (special invoices for reimbursement available monthly upon request) for possible reimbursement

[ ]  I have an Out-of-Network insurance plan and will **not** be submitting for possible Out-of-Network Reimbursement

[ ]  I am a private pay client (not on a sliding scale)

[ ]  I have an agreed-upon sliding scale fee

**Personal Cost Estimation**

We have broken down current costs for 3, 6, 12-month services for 55- and 90-minute sessions below:

3 months weekly 55-minute session full fee or out-of-network fee (12 sessions): $1800.00

3 months weekly 90-minute session full fee or out-of-network fee: $2700.00

6 months weekly 55-minute session full fee or out-of-network fee (24 sessions): $4050.00

6 months weekly 90-minute session full fee or out-of-network fee: $5400.00

1 year weekly 55-minute session full fee or out-of-network fee (48 sessions): $8100.00

1 year weekly 90-minute session full fee or out-of-network fee: $10800.00

Variable based on pre-agreed upon Sliding scale ($x/session x 52) = $x

\*To reduce paper waste, this form will be kept in your client confidential file. If you would like a copy for your records, please request\*

**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. GFE Standard Notice GFE Standard Notice.

Appendix 1 Standard Notice: “Right to Receive a Good Faith Estimate of Expected Charges” Under the No Surprises Act (For use by health care providers no later than January 1, 2022) Instructions 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 file 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” of expected charges. This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a “Good Faith Estimate” to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the availability of a “Good Faith Estimate” must be prominently displayed on the convening providers and convening facility’s website and in the office and on-site where scheduling or questions about the cost of health care occur. To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance with the good faith estimate requirements to inform an individual of their rights to receive such a notice. Use of this model notice is not required and is provided as a means of facilitating compliance with the applicable notice requirements. However, some form of notice, including the provision of certain required information, is necessary to begin the patient-provider dispute resolution process.

***BY SIGNING THIS DOCUMENT I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.***

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 don’t 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 legal fees, copying files, cancellation fees, 85-minute sessions.

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 healthcare 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. For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_