Resilience Psychiatric Services, LLC

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Provider EIN # _81-2148099_______

Provider NPI# _1083911598_______

Date: ________________________________ Expiration Date: ________________________________

GOOD FAITH ESTIMATE

Patient Name:	
Patient Date of Birth:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable): N/A	
IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed. Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment. **It is within your rights to decline a formal diagnosis.**	

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental 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 are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a doctor to know, in advance, how many medication review sessions may be necessary or appropriate for a given person upon the initiation of treatment, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of medication review visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your doctor. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The one-time fee for an initial diagnostic assessment (in-person or via telehealth) is **$450 (CPT Code (GT)90792)**.

Beyond this, the fee for a medication review up to 30**-minutes** (in-person or via telehealth) is **$200 (CPT Code (GT)99214)**. Most patients will attend one medication review visit per month, but the frequency of visits that are appropriate in your case may be more or less than once per month, depending upon your individual needs and preference. It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time.

You may project any potential future cost(s) by multiplying the session fee of **$200** by the total number of sessions. This will result in your total estimated cost for mental health service(s).

For example, $200 session fee X 12 sessions =$2400.00.

Your total estimated charges will increase according to the number of visits and length of treatment.

Resilience Psychiatric Services, LLC recognizes every patient's treatment journey is unique. How often you attend sessions and length of those sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Doctor's availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your doctor will continually assess the appropriate frequency of sessions and will work together to determine when you have met your goals and are ready for discharge and/ or a new "Good Faith Estimate" will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate 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. Your provider may recommend additional services that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated

costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the Informed Consent documentation and should these items / services be initiated a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your doctor at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

For questions or more information related to the Good Faith Estimate, visit www.cms.go/nosurprises or call (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place.

With my signature for this Good Faith Estimate, I acknowledge that I am not obligated or required to obtain any of the listed services from this provider and that I am consenting of my own free will, free from coercion or pressure. I also understand that:

- I am giving up some consumer billing protections under federal law.
- I agree to pay for out-of-network care provided by **Resilience Psychiatric Services, LLC**.
- I may get a bill for the full charges for these items and services or must pay out-of-network cost-sharing under my health plan.
- I was given notice explaining that my provider and/or practice is not in my health plan's network, the estimated costs of services, and what I may owe if I agree to be treated by this provider and/ or practice.
- I have received notice both verbally and written/ electronically.
- I fully and completely understand that some or all amounts that I pay may not count towards my health plan's deductible, co-pay, co-insurance, or out-of pocket limit.
- I can end this agreement by notifying the provider and/ practice in writing before receiving items and/ or services.

IMPORTANT: You are not required to sign this form; however, if you do not sign, the provider and/ or practice may not treat you. You have the right to choose to get care from a provider and/or practice that is within your health plan's network.

______________________________ ______________________________ ____________________

Print Name Signature Date