No Surprises Act Calculation Worksheet

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| Gross annual  household income | 1-3 persons in household  Price per session  45mins/60mins | **1-3 persons in household**  **Annual** Good Faith Estimate for sessions every other week (26) | 4+ persons in household  Price per session  45mins/60mins | **4+ persons in household**  **Annual** Good Faith Estimate for sessions every other week (26) |
| Below $22,330 | $1-$35/$45 | $910/$1170 | $1-$30/$40 | $780/$1040 |
| $22,331-25,999 | $35/$45 | $910/$1170 | $30/$40 | $780/$1040 |
| $26,000-30,999 | $35/$45 | $910/$1170 | $30/$40 | $780/$1040 |
| $31,000-37,999 | $45/$55 | $1,170/$1430 | $40/$50 | $1,040/$1300 |
| $38,000-45,999 | $55/$65 | $1,430/$1690 | $50/$60 | $1,300/$1560 |
| $46,000-53,999 | $65/$75 | $1,690/$1950 | $60/$70 | $1,560/$1820 |
| $54,000-60,999 | $75/$85 | $1,950/$2210 | $70/$80 | $1,820/$2080 |
| $61,000-69,999 | $85/$95 | $2,210/$2470 | $80/$90 | $2,080/$2340 |
| $70,000-79,999 | $95/$105 | $2,470/$2730 | $90/$100 | $2,340/$2600 |
| $80,000-  $89,999 | $105/$115 | $2,730/$2990 | $100/$110 | $2,600/$2860 |
| $90,000-$99.999 | $115/$125 | $2,990/3250 | $110/$120 | $2,860/3120 |
| $100,000 and over | $125/$135 | $3,250/$3510 | $120$130 | $3120/$3380 |

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| --- | --- |
| 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. |

**No Surprises Act**

**(OMB Control Number: 0938-1401)**

**GOOD FAITH ESTIMATE**

**For Health Care Items & Services**

**Effective January 1, 2022**, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

**Under Section 2799B-6 of the Public Health Service Act (PHSA**), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

**Note:** The PHSA and GFE does not currently apply to clients who are using insurance benefits, including "out of network benefits'' (i.e., submitting superbills to insurance for reimbursement).

However,we are furnishing this information to all clients so that you may understand your estimated charges in the event that your health insurance expires, or you choose to become a cash pay client. These charges would also apply if you received services after the expiration of your health insurance plan and did not give us prior notification of the expiration.

**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.

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 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.

**GOOD FAITH ESTIMATE**

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| --- | --- | --- |
| **Provider name: Brittney Brown, MA, LPC**  **Renewed Hope Counseling, LLC** | NPI:1104583087 | Tax: 93-2471138 |
| **Service Address:** 737 Dunn Rd Hazelwood, MO 63042 | | |

**For Health Care Items & Services**

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| --- | --- | --- |
| **CLIENT INFORMATION** | | |
| First Name: Initial: Last name: | | Date of Birth: |
| Address: | | |
| City, State, Zip: | Primary phone: | |
| Responsible Party Name:  Relationship to client: | | |

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| **TREATMENT & FEES** | | | | | |
| **Diagnosis/ Code Primary:** | | R69  Z65.9 | Diagnosis deferred  Problem related to unspecified psychosocial circumstance | | |
| **Primary Services Scheduled:** 45- or 60-minutes Individual Psychotherapy  **Additional Services:** *Missed appt fee assessed at $25 a missed session*  **Estimated Duration of services:** One year **Scheduled dates of service:** every other week (total of 26), recurring appointment | | | | | |
| **Service Code:** | **Service Type:** | | **Fee:** | **Frequency:** | **Annual Estimate:** |
| **90834** | **Individual Psychotherapy 45min** | | $ | Approx. 26 visits per yr. | $ |
| **90837** | **Individual Psychotherapy 60min** | | $ | Approx. 26 visits per yr. | $ |
| **90846** | **Family or Couples therapy w/o client** | | $ | Approx. 26 visits per year | $ |
| **90847** | **Family or Couples Therapy** | | $ | Approx. 26 visits per year | $ |
|  |  | |  | **TOTAL ANNUAL COST:** | $ |

**\*Client or Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Date of Agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**