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**2022 FEE SCHEDULE AND GOOD FAITH ESTIMATE**

In accordance with the No Surprises Act

You are receiving this notice because this provider or facility isn’t in your health plan’s network and is considered out-of-network. This means the provider or facility does not have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more. If your plan covers the item or service you are getting, federal law protects you from higher bills when:

• You are getting emergency care from an out-of-network provider or facility, or

• An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you’re not sure if these protections apply to you. If you sign this form, be aware that you may pay more because:

• You’re giving up your legal protections from higher bills.

• You may owe the full costs billed for the items and services you get.

• Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility.

**Prior authorization or other care management limitations:**

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan’s approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

**More information about your rights and protections**

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

►Questions about your rights? Contact 1-800-985-3059

**Good Faith Estimate**

**Provider Information:**

Barbara J. Shaya, LPC / Mindfulness Counseling Services LLC

725 South Adams, Suite #242, Birmingham, MI 48009

(248) 558-0950

State of Michigan License #6401011477 / Tax ID #82-2856998

NPI(1) 1629535877 / NPI(2) 1922567551

**Client Name:**

**Client Date of Birth:**

**Diagnostic Code(s):**

You are entitled to receive this Good Faith Estimate of what the charges could be for counseling services provided to you. While it is not possible for a therapist to know, in advance, how many sessions may be necessary or appropriate for a given client, this form provides an estimate of the cost of services provided. Your total actual cost will depend upon the number of counseling sessions you attend, your individual circumstances and the type and amount of services that are provided to you.

There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from Mindfulness Counseling Services LLC, nor does it include any services rendered to you that are not identified here.

The fee for an initial 90-minute counseling session (CPT#90791) for new clients is $150.00. Thereafter, a 60-minute counseling session (CPT#90837), in-person or via telehealth, is $110.00. Most clients will attend one counseling session per week, but the frequency of sessions that are appropriate in your case may be more or less than once per week, depending on your needs. Based on a fee of $110.00 per session, the following are expected charges for counseling services:

|  |  |  |  |
| --- | --- | --- | --- |
| Number of Weeks | 1 session per week | 2 sessions per week | 2 sessions per month |
| 1 week of service | $110 | $220 |  |
| 13 weeks of service (approximately 3 months) | $1430 | $2860 | $660 |
| 26 weeks of service (approximately 6 months) | $2860 | $5720 | $1320 |
| 48 weeks of service (approximately 1 year excluding vacations and holidays) | $5280 | $10560 | $2640 |

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 counseling sessions. The number of counseling sessions 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 therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

By signing, I understand that I’m giving up my federal consumer protections and may have to pay more for out-of-network care. With my signature, I am agreeing to receive services from Mindfulness Counseling Services LLC:

☐ **With my signature, I acknowledge that:**

* I have read and understand this notice and the Good Faith Estimate.
* I am giving up some consumer billing protections under federal law.
* I may have to pay the full charges for these services or must pay additional out-of-network cost-sharing under my health plan.
* I was given a written notice that explained my provider or facility isn’t in my health plan’s network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
* I received the notice either on paper or electronically, consistent with my choice.
* I fully and completely understand that some or all the amounts I pay might not count toward my health plan’s deductible or out-of-pocket limit.
* I can end this agreement by notifying the provider or facility before getting services.

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Client’s signature (Parent/Guardian if minor client)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of client (Parent/Guardian if minor client)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of signature

Take a picture and/or keep a copy of this form. It contains important information about your rights and protections