

## Lakes Country Counseling

Re: Good Faith Estimate

Date:

Dear:

In compliance with the No Surprises Act that went into effect January 1, 2023, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing".

This act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (see attached). It is difficult to determine the true length of treatment for mental health care and each client has a right to determine how long they would like to participate in psychotherapy services. Therefore, attached you will find the fee schedule for the services offered by your therapist. Your therapist will corroborate with you to determine how many sessions you may need.

Please review the Good Faith Estimate and discuss any questions or concerns you may have with your therapist. You may also contact Lakes Country Counseling's Billing Specialist Sara Foster, Office Manager, Allysa Price or Billing Assistant Hannah Hall with any questions as well.

Sincerely,

Tracey Malone M.S., LMFT-S

Clinical Director

Lakes Country Counseling

7251 Excelsior Road

Baxter, MN 56425

The fee for a traditional 53 minute psychotherapy session (in person or via telehealth) is currently \$125.00. Most clients will attend one therapy session per week. You may project any future costs by multiplying the session fee of \$125 by the total number of sessions. For example, \$125 session fee x 4 sessions= \$500 per month. If you attend therapy for a longer period of time, your estimated charges will increase according to the number of visits and length of treatment.

We are providing you with this GFE based on the information the clinician has available at this time: actual items, services, or charges may differ from the GFE as treatment progresses.

The fee schedule below is the same for both in-office services and for telehealth services.

Diagnostic Assessment/Intake	\$150	Plus Interactive Complexity =	\$165
Individual session:	\$125	Plus Interactive Complexity=	\$140
Interactive Complexity	\$15		

All sessions should be calculated using **BOTH** the cost of the session **PLUS** the interactive complexity fee.

One diagnostic assessment/intake \$165 **Totals below would be in addition to the \$165 for the initial diagnostic assessment/intake**

[ ] 10 Individual and/or family sessions + Interactive complexity	\$1400
[ ] 12 individual and/or family sessions + Interact complexity	\$1680
[ ] 26 individual and/or family sessions +Interactive complexity	\$3,640
[ ] 32 individual and/or family sessions + Interactive complexity	\$4,480
[ ] 52 individual and/or family sessions + Interactive complexity	\$7,280

**Estimated Total Cost for Anticipated Services:** \_\_\_\_\_ 53 minute sessions at \$125 per session and \_\_\_\_\_ Interactive Complexity add on at \$15 per session for a total of \$ \_\_\_\_\_

If your bill is \$400 more than the GFE, federal law allows you to dispute your bill and begin the dispute resolution process with the US Department of Health and Human Services (HHS) by visiting [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or by calling 1-800-985-3059. If you choose to begin the resolution process, you must start within 120 calendar days of the date of the ORIGINAL bill. If you dispute the bill, the agency cannot move the bill into collections and/or must cease collection efforts. The agency must also suspend any accrual fees. The agency cannot threaten any retribution for disputing your bill.

There is a \$25 fee to use the dispute process. If the Selected Dispute Resolutions (SDR) entity reviewing your dispute agrees with you, you will have to pay the price of the GFE provided to you, reduced by the \$25 fee. If the SDR entity disagrees with you and agrees with the agency, you will have to pay the higher amount.

☐ Denies copy of GFE

Client Signature: _____	Date: _____
Printed Name: _____	Date: _____
Legal Guardian Signature (if applicable) _____	Date: _____
Printed Name: _____	Date: _____
Clinician Signature: _____	Date: _____
Clinician Typed Name and Credentials: _____	Date: _____