Mind In Balance, LLC

Heal ~ Grow ~ Connect

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License: 62628

Notice of Good Faith Estimate

No Surprises Act: Good Faith Estimate for Health Care Items and Services

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost you.

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 medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good FAith Estimate in writing at least one (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 rights to a Good Faith Estimate, visit www.cms.gov/nosurprises.

General List of Charges Possible for Mind In Balance, LLC

The following is a detailed list of expected charges. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Note the maximum estimated amount does not include late cancellation/no show fees, crisis sessions, or non-therapeutic charges such as documentation fees, court fees, or banking fees.

Psychotherapy:

00000 - Initial Phone Consult, 10 minutes: $0.00

90791 - Initial Intake Session (Psychiatric Diagnostic Evaluation), 50 minutes: $145.00

90832 - Individual Psychotherapy, 16-37 minutes: $70.00

90834 - Individual Psychotherapy, 38-52 minutes: $125.00

90837 - Individual Psychotherapy, 53-60 minutes: $130.00

90839 - Psychotherapy Crisis, 53-60 minutes: $145.00

90840 - Additional Psychotherapy Crisis, 16-37 minutes: $80.00

90846 - Family Psychotherapy, conjoint psychotherapy w/o patient present, 50 minutes: $130.00

90847 - Family Psychotherapy, conjoint psychotherapy w/ patient present, 50 minutes: $130.00

Couples Session, 85-90 minutes: $170.00

Couples Session, 53-60 minutes: $130.00

Wellness Group Intakes, 55 minutes: $100.00

Wellness Groups, 120 minutes: $50.00

Any In-Person Visit Outside the Office

(inpatient visits, court, collaborative law services, etc.): $250.00 per hour

Written Reports/Paperwork (insurance companies, supervisors, court/legal, etc.): $125.00

Insufficient Funds/Returned Check Fee per item: $25.00

Length of Services

Psychotherapy services can range from two days, to two months, to a year or more. The length of time you will need to be in therapy is based on your therapeutic goals, your overall wants and needs, and any psychosocial/financial barriers that may arise. With this being said, communication is key to any healthy relationship. Should a financial hardship occur, you are encouraged to discuss your situation with your therapist to determine the best resolution as it pertains to your continuity of care and the therapeutic relationship. Should more time be required to meet your therapeutic goals, your therapist will discuss your options with you at which time a new Good Faith Estimate will be created, your therapeutic services will end, or you will be referred to another provider. The above-listed total estimated psychotherapy cost, based on a 52-week structure at the individual rate of $130.00 per session once a week and an intake fee of $145.00 equates to $6,775.00 a year for an individual with weekly sessions. The cost for a couple with weekly sessions would be $8,840.00. These totals DO NOT account for no-show/late cancellation fees, bank charges, crisis sessions, or non-therapeutic charges such as insurance paperwork or court.

Disclaimer

The 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 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 $25.00 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on the 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 or 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.

Provider Estimate

A personalized estimate has been sent to your email address. Please review it carefully.

Insurance Opt-out/Acknowledgment of No Insurance, Understanding of Fee Schedule, Understanding of Personalized Provider Estimate:

By eSigning this form, I acknowledge that I don't have insurance or I am opting out of using my insurance; I acknowledge that I have read and understood the fee schedule; and I acknowledge that I have received my personalized estimate from Mind In Balance, LLC and read and understood it. My electronic signature has the full force and effect of a signature affixed by hand to a paper document.

I have read and I agree to Notice of Good Faith Estimate

Signature of Client or Legal Guardian	***DOB***	***Date***
Sign Full Name	*MM-DD-YYYY*	*MM-DD-YYYY*