

Life Strategy Center

Helping Change Lives for the Better

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GOOD FAITH ESTIMATE INFORMATION

Date of Estimate:

Therapist:

Patient Name:

Patient Date of Birth:

Patient Address:

Primary Diagnosis and Diagnosis Code: To be determined per 90791 Diagnostic Evaluation:

Services Requested: (Individual counseling; family; couples; group)

Date of Initial Session:

You are entitled to this Good Faith Estimate of the potential charges for clinical services provided to you. While it is not possible for the provider to know in advance how many sessions may be necessary or appropriate for a given person/family/group, this provides an estimate of the cost of services. Your total cost of services will depend on your individual circumstances, and the type, number and amount of services provided for you.

This Good Faith Estimate shows the costs of reasonable and expected services for your health care needs. 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. This estimate is based on information known at the time the estimate was created and does not include any unknown or unexpected costs that may arise during treatment. There may be additional services recommended as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charged stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charged.) You can ask 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 US Department of Health and Human Services. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days 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. For questions or information about your right to a Good Faith Estimate or the dispute resolution process, visit <https://www.cms.gov/nosurprises/consumers> or call 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of services furnished to you.

Life Strategy Center is unable to anticipate your treatment needs until after your first appointment. Sessions are considered to be 50 minutes in length. Based on a fee of \$140 per session, the following are expected charges:

NUMBER OF WEEKS:	TOTAL ESTIMATED CHARGES:	TOTAL ESTIMATED CHARGED:
	<u>1 session per week</u>	<u>2 sessions per week</u>
1 week of service	\$140.00	\$280.00
13 weeks of service	\$1820.00	\$3640.00
39 weeks of service	\$5460.00	\$10,920.00
52 weeks of service	\$7280.00	\$14,560.00

These charges reflect individual and/or family therapy costs for a 50 minute session. Group sessions are calculated at a different rate and are available upon request from your group therapy facilitator (s). Charges for any costs associated with evaluations (test materials, written report) are also not reflected here. These may be discussed with your provider.

This Good Faith Estimate is not intended to serve as a recommendation for treatment nor as a prediction of the specific number of psychotherapy sessions you may need to attend. 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 therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time. You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

90791 Psychiatric Diagnostic Evaluation (first one or two sessions)	\$140.00
90837 Individual Psychotherapy Session (50 minutes)	\$140.00
90847 Family Psychotherapy Session	\$140.00
Sessions (other than groups) that exceed 50 minutes will be charged accordingly (75 minutes = \$175.00; 90 minutes = \$210.00; 120 minutes = \$280.00)	

Costs for Chronic Pain Management group and any other group therapy sessions will be provided upon enrollment in those groups.