GOOD FAITH ESTIMATE

Prairie Sky Counseling LLC • Michele D. Ogburn, LCSW, LIMHP

Effective Date: April 1, 2026

Patient & Estimate Information

Patient/Client Name	_____	**Estimate Date**	_____
Date of Birth	_____	**Expected Start Date**	_____
Estimated Frequency	_____	**Estimated Duration**	_____
Insurance Status	■ Uninsured ■ Self-Pay / Choosing Not to Use Insurance		

What is a Good Faith Estimate?

A Good Faith Estimate (GFE) provides an estimate of expected charges for health care services for individuals who do not have health insurance or who choose not to use their insurance. Under the No Surprises Act, providers generally must provide a written GFE when requested or when services are scheduled sufficiently in advance. This estimate is not a bill and does not guarantee the final cost of care.

Estimated Services & Charges

Service / CPT	Description	Units / Visits	Estimated Charge
90791	Initial diagnostic evaluation / intake	1	$250
90837	Individual psychotherapy / telehealth	As clinically indicated	$160
90847	Couples / family psychotherapy / telehealth	As clinically indicated	$220
90846	Other clinically necessary service	As clinically indicated	$220

Estimated Cost of Care

Intake / diagnostic evaluation (CPT 90791): $250

Individual psychotherapy (CPT 90837): $160 per session

Couples / family psychotherapy (CPT 90847): $220 per session

Other / family psychotherapy without patient present (CPT 90846): $220 per session

Important Information About This Estimate

• This Good Faith Estimate is based on information known or reasonably anticipated at the time it is prepared.

• The estimate is not a bill, contract, or guarantee of the amount that will ultimately be charged.

• Actual care may differ from the services, frequency, duration, or number of sessions anticipated in this estimate.

• Additional services may become clinically appropriate or necessary and may result in additional charges.

• Services provided by another provider or facility are not included unless specifically listed in this estimate.

• Because mental health treatment is individualized, the duration and frequency of treatment may change based on clinical need and client preference.

• If a client has insurance but chooses not to use it, the client is responsible for understanding any consequences of self-pay.

• Clients should retain this estimate and compare it with their final bill.

Patient-Provider Dispute Resolution

If you are uninsured or self-pay and your final bill is at least $400 more than the expected charges shown on your Good Faith Estimate for that provider, federal law may provide a process to dispute the bill. The federal dispute process has specific eligibility and filing requirements. Information is available through CMS and the No Surprises Help Desk.

Client Acknowledgment

By signing below, I acknowledge that I received and reviewed this Good Faith Estimate and understand that it is an estimate of expected charges, not a bill or guarantee of the final cost of care.

Client/Authorized Representative Signature: _____	Date: _____
Provider: Michele D. Ogburn, LCSW, LIMHP	Date: _____

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