HOLY FAMILY COUNSELING CENTER
4411 Suwanee Dam Rd, Suite 720
Suwanee, GA 30024 | (678) 993-8494

Elizabeth Casarez
MS, LAPC

Good Faith Estimate of Health Care Services

Patient Information

Date: _____

Patient(s) Name: _____ Date of Birth: ____/___/_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred phone to contact you: Cell: _____Home: _____Work: _____

Email: _____ Preferred Contact: ____ By Mail ____ By Email

Patient Diagnosis

Primary Service Requested/Scheduled: Please see attached list of itemized services and fees.

Patient Primary Diagnosis: Z65.9 or _____**Secondary Diagnosis Code:** N/A

If scheduled, list the date the primary service will be provided: _____

____ Check here if this service has not yet been scheduled.

Date of Good Faith Estimate: ___/____/___

Summary of Expected Charges: See the itemized estimate attached for more detail.

Holy Family Counseling Center and its therapists, counselors and social workers are considered "out of network" providers and are not paneled with any insurance companies.

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

Estimate for outpatient psychotherapy/counseling.

Holy Family Counseling Center
4411 Suwanee Dam Road, Suite 720
Suwanee, Ga 30024
Tax Identification Number: 27-0997764

Provider:
Elizabeth Casarez, MS, LAPC
678-993-8494
info@holyfamilycounselingcenter.com
National Provider ID: 1669160222

Please check the location(s) of where client expects to receive outpatient psychotherapy/counseling.

_____ Main Office: 4411 Suwanee Dam Road, Suite 720, Suwanee, Ga 30024
_____ Alpharetta Office: St. Thomas Aquinas Catholic Church, 535 Rucker Road, Alpharetta, GA 30004
_____ Tele Health

Service Provided: Outpatient psychotherapy/counseling
Diagnosis Code: Z65.9 - Unspecified Problem related to unspecified psychosocial circumstances.
Service CPT Code: 90889 or 90837. *Please circle the one that applies.*

Quantity of Sessions: Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns.

Expected Cost: This Good Faith Estimate explains your therapist's rate for each service provided. Please note the expected cost is based on the fee multiplied by the number of sessions needed, as determined in collaboration with your therapist.

Total expected charges from Holy Family Counseling Center to be determined as stated above.

Additional Health Care Provider/Facility Notes:

The therapist and client have agreed to an adjusted fee for service of $_____ for CPT Code 90837 to begin on _____and be reevaluated on _____. *Client and therapist, please initial here.* _____.

Good Faith Estimate - Table of Services and Fees

Patient Name: _____

Service Code (CPT Code)	Description	Fee for Service (Number of sessions will be determined as We progress with therapy)
90889	Initial Interview	$125
90832	Individual Outpatient Psychotherapy, approximately 30 minutes	$63
90834	Individual Outpatient Psychotherapy, approximately 45 minutes	$125
90837	Individual Outpatient Psychotherapy, approximately 50-60 minutes.	$125
90846	Family Psychotherapy without Patient Present, approximately 50-60 minutes.	$125
90847	Family Psychotherapy with Patient Present, approximately 50-60 minutes	$125
90853	Group Psychotherapy – per individual	$40
90832-95	Tele Mental Health – approx. 30 minutes	$63
90834-95	Tele Mental Health – approx. 45 minutes	$125
90837-95	Tele Mental Health – approx. 50-60 minutes	$125
Cancellation Fee	Your therapist requires cancellation notification 24 hours prior to your appointment if you are unable to keep your appointment. You are responsible for the fee of the missed appointment.	$125
Reproduction of Records	HFCC follows state guidelines for reproduction of records costs. These can be found under the Georgia General Assembly Unannotated Code §31-33-3.	$25.88 search fee Pages 1-20 $0.97 per page. Pages 21-100 $0.83 per page.
Bank Fee	Returned check fee	$25
Service Charge	Credit card service charge -charged per transaction $155 or less. This service charge may increase for any credit card transaction greater than $155.	$5

Total Estimate: This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

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Please note, our services do not include court appearances. If we are subpoenaed for any reason, there will be a special rate assessed for these services and a new Good Faith Estimate will be provided for that service.

Disclaimer:
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your healthcare 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 at least $400 more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed 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 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 and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019. Keep a copy of this Good Faith Estimate that we provided to you in a safe place and/or take a picture of it. You may need it if you are billed a higher amount.

This Good Faith Estimate is not a contract and does not require the uninsured or self-pay individual to obtain the items and services from any of the providers or facilities identified in this Good Faith Estimate. Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you and any questions or concerns have been addressed. Thank you.

_____ or _____
Patient's signature — Guardian/authorized representative's signature

_____ or _____
Print name of Patient — Print name of guardian/authorized representative

_____ _____
Date and time of signature — Date of signature