

# Good Faith Estimate

In compliance with the No Surprise Act Federal Law, the following is a detailed list of expected charges for mental health services with Edmond Counseling and Professional Development.. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

## Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

**IMPORTANT:** You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

## Estimate of what you could pay if you give up your protections

**Patient Name**

**Out-of-network provider or facility name-** Edmond Counseling and Professional Development, LLC

**Total cost estimate of what you may be asked to pay:** **\$1980**

**The details of this estimate is found on the following pages**

**\*Please note, this is only an estimate.** Your out of pocket expense may be less if your treatment duration is less than the average length. If your treatment exceeds the average length and cost, you will receive a new Good Faith Estimate.

► Review your detailed estimate. See following pages for a cost estimate for each item or service you'll get.

► Call your health plan. Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

► Questions about this notice and estimate? Contact Micah Perkins at [hello@edmondcounseling.com](mailto:hello@edmondcounseling.com) or call/text 405 440 3034.

► Questions about your rights? Contact : 1-800-985-3059

Prior authorization or other care management limitations-

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

#### **More information about your rights and protections**

Visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

## **By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.**

With my signature, I'm agreeing to get the items or services from (select all that apply):

#### **Indicate Provider and Facility Providing Services**

Provider- Amanda Beck, M.A., L.P.C.

Provider- Hayley Twyman-Brack, M.A., L.P.C.

Provider- Jimmy Leverette, M.S., L.P.C.

Provider- Micah Perkins, M.S, L.P.C, L.A.D.C.

Provider- Terri Shuelein, M.Ed., L.P.C.

Facility- Edmond Counseling and Professional Development, LLC

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

**IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.**

**Signature of Patient/ Guardian/ Authorized Representative**

**Print Name**

**Today's Date**

**Time**

**Take a picture and/or keep a copy of this form.  
It contains important information about your rights and  
protections.**

**To receive a copy via email, enter your email address here**

## **More details about your total cost estimate**

**Patient Name**

**Out-of-network provider or facility name-** Edmond Counseling and Professional Development, LLC

**Diagnosis-** To be determined at intake session, as well as, on going assessment based upon emerging information gathered during treatment.

**Services-** Number of counseling sessions required for treatment is dependent upon the severity of the condition, support systems in place, compliance with treatment recommendations, and chronicity of the condition.

The following estimate is based on the average length of treatment required for patients to receive relief from their symptoms.

If your treatment exceeds the average length of time for treatment, you will receive a new estimate.

**Estimate-**

One (1) Intake Session- \$180

and twelve (12) Counseling Sessions (53-60 min, typical CPT Code 90837 and/or 90847 and/or 90846)- \$150 x 12= \$1800

**Estimated Total- \$1980**

This estimate does not include other fees which may be incurred such as cancelation fees, or court fees if the therapist is required to testify.

**\*Please note, this is only an estimate.** Your out of pocket expense may be less if your treatment duration is less than the average length. If your treatment exceeds the average length and cost, you will receive a new Good Faith Estimate.

For questions about fees contact Edmond Counseling and Professional Development's billing department or the Director- Micah Perkins at hello @edmondcounseling.com or call/text (405) 440-3034.