# GOOD FAITH ESTIMATE FOR HEALTHCARE SERVICES

PORTLAND MENTAL WELLNESS
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DATE OF GOOD FAITH ESTIMATE: ____________________

## CLIENT INFORMATION

CLIENT NAME:______________________________DATE OF BIRTH:____________________
CLIENT IDENTIFICATION NUMBER: ____________________
ADDRESS: ________________________________________________
CITY:____________________ STATE:__________ ZIP CODE:______________ PHONE:____________________
EMAIL ADDRESS:________________________________________________
CLIENT CONTACT PREFERENCE: ☐ MAIL ☐ EMAIL

## CLIENT DIAGNOSIS

PRIMARY SERVICE* REQUESTED/SCHEDULED: ☐ INITIAL DIAGNOSTIC EVALUATION ☐ PSYCHOTHERAPY SERVICES
CLIENT PRIMARY DIAGNOSIS: ______________________________ PRIMARY DIAGNOSIS CODE: ______________
WHICH OPTION BEST DESCRIBES THE SCHEDULED DATES OF MENTAL HEALTH SERVICES?

☐ Services began prior to commencement of the No Surprises Act' on January 1, 2022 and will only continue based upon an ongoing, collaborative, and informed agreement between Portland Mental Wellness | Ryan Grassmann, M.A., LPC and the client. Medical necessity for mental health services shall dictate the frequency and duration of all services. Your services will be subject to change based upon your choice and your mental health circumstances. The estimated service period described in this Good Faith Estimate will incorporate a period of 12 months from the date listed above.

☐ Services have not yet been scheduled.

*(Please see reverse side for a list of itemized services and fees)

The following is a detailed list of expected charges for psychotherapy/psychological assessment/or other service. The number of sessions over the course of 12 months is based on your needs, life events, goals and financial situation. So, you are in control of this estimate. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. A new estimate will be provided should fees and/or frequency of services change.

## PRIMARY MENTAL HEALTH SERVICE REQUESTED

| SERVICE | ADDRESS WHERE SERVICE WILL BE PROVIDED | DIAGNOSIS CODE | SERVICE CODE | # OF SESSIONS | EXPECTED COST OVER 12 MO. PERIOD |
|---|---|---|---|---|---|
| ☐ INTAKE ASSESSMENT 90791<br>☐ INDIVIDUAL PSYCHOTHERAPY 90837<br>☐ RELATIONSHIP THERAPY 90847 | ☐ 1235 SE DIVISION ST, SUITE 207<br>☐ TELEMENTAL HEALTH PLATFORM | ☐ Z65.8<br>☐ EXISTING DIAGNOSIS__________ | ☐ 90791<br>☐ 90837<br>☐ 90847<br>☐ OTHER__________ | | $ |

ADDITIONAL HEALTH CARE PROVIDER NOTES:

## PORTLAND MENTAL WELLNESS

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NATIONAL PROVIDER IDENTIFICATION: 1891152047 | TAXPAYER IDENTIFICATION: 47-4457126

## DISCLAIMER

This Good Faith Estimate shows the costs of services that are reasonably expected for your health care needs. This estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unkown 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 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 assitance 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 dipsute resolution process, you must start the dispute process within 120 calendar days (about four 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 prices 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.

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.

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.

## TABLE OF SERVICES AND FEES

| DATE OF SERVICE (IF KNOWN) | SERVICE CODE (CPT CODE) | DESCRIPTION | FEE FOR EACH TYPE OF SERVICE | ADJUSTED FEES FOR PRIVATE PAY |
|---|---|---|---|---|
| | 90791 | INITIAL DIAGNOSTIC EVALUATION (APPROX. 60 MIN.) | $220 | |
| | 90832 | PSYCHOTHERAPY (16-37 MIN.) | $95 | |
| | 90834 | PSYCHOTHERAPY (38-52 MIN.) | $175 | |
| | 90837 | PSYCHOTHERAPY (≥ 53 MIN. — THIS IS THE HOURLY RATE USED FOR ALL PRO-RATED CALCULATIONS) | $190 | |
| | 90839 | PSYCHOTHERAPY FOR A CRISIS, 30-74 MIN. | $220 | |
| | +90840 | PSYCHOTHERAPY FOR A CRISIS (ADD ON CODE FOR EACH ADDITIONAL 30 MIN.) | $95 | |
| | 90846 | FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT (60 MIN.) | $195 | |
| | | FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT (90 MIN.) | $225 | |
| | 90847 | FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT (60 MIN.) | $195 | |
| | | FAMILY PSYCHOTHERAPY WITH PATIENT PRESENT (90 MIN.) | $225 | |
| | 90853 | GROUP PSYCHOTHERAPY | $45 | |
| | 99354 | PROLONGED SERVICE IN ADDITION TO PRIMARY SERVICE | $90 | |
| | LATE CANCEL/ NO SHOW | YOUR THERAPIST REQUIRES A 24-HOUR CANCELATION FEE | FEE OF SCHEDULED SERVICE | |
| | FILE PREP | PREPARATION AND MAILING OF CLINICAL FILES | $90/HOUR + MAILING COSTS | |
| | **This Good Faith Estimate explains your therapist's rate for each individual 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.** | | TOTAL ESTIMATE $ | ADJ. TOTAL ESTIMATE $ |

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

## GOOD FAITH ESTIMATE SIGNATURE

Your signature below indicates that your provider has explained this Good Faith Estimate with you and that your questions or concerns have been addressed. Thank you!

PRINTED NAME

PRINTED NAME

SIGNATURE DATE

SIGNATURE DATE