Weekend Behavioral Health

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Good Faith Estimate Form

Patient Information:

Name: _____ Today's Date: _____

Address: _____

Patient Identification Number: _____

Phone numbers: Home: _____ Cell: _____ Work: _____
E-mail: _____

What is the best way and time to contact you? _____

Patient Diagnosis:

Primary Diagnosis / Primary Diagnosis Code: _____

Secondary Diagnosis / Secondary Diagnosis Code: _____

Standard Fees:

For child and adolescent initial evaluation/intake (90 minutes), my fee is 750.00.

For adult initial evaluation/intake (60 minutes), my fee is 500.00.

For follow up medication management appointments (30 minutes) my fee is 250.00.

For psychotherapy or combination (psychotherapy and med management) appointments (60 minutes), my fee is 500.00.

Other miscellaneous services such as filling forms, telephone correspondence, prior authorizations, court hearings, etc. will be billed at rate of 125.00 per 15 minutes increment with a minimal charge of 15

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minutes (125.00). Fees may be subject to change. If Dr. Wang's fees are to increase, Dr. Wang will provide you a 30-day notice to alert you to the change.

Estimate:

If scheduled, list the date(s) the Primary Service or Item will be provided: _____

[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____

Total estimated cost for one year of services:

[ ] Child and adolescent patient (intake + weekly medication only follow up appointments):

$750.00 + ($250.00 x 51) = $13500.00

[ ] Child and adolescent patient (intake + Bi-weekly medication only follow up appointments):

$750.00 + ($250.00 x 25) = $7000.00

[ ] Child and adolescent patient (intake + monthly medication only follow up appointments):

$750.00 + ($250.00 x 11) = $3500.00

[ ] Child and adolescent patient (intake + weekly medication + therapy follow up appointments):

$750.00 + ($500.00 x 51) = $26250.00

[ ] Child and adolescent patient (intake + Bi-weekly medication + therapy follow up appointments):

$750.00 + ($500.00 x 25) = $13250.00

[ ] Child and adolescent patient (intake + monthly medication + therapy follow up appointments):

$750.00 + ($500.00 x 11) = $6250.00

[ ] Adult patient (intake + weekly medication only follow up appointments):

$500.00 + ($250.00 x 51) = $13250.00

[ ] Adult patient (intake + Bi-weekly medication only follow up appointments):

$500.00 + ($250.00 x 25) = $6750.00

[ ] Adult patient (intake + monthly medication only follow up appointments):

$500.00 + ($250.00 x 11) = $3250.00

[ ] Adult patient (intake + weekly medication + therapy follow up appointments):

$500.00 + ($500.00 x 51) = $26000.00

[ ] Adult patient (intake + Bi-weekly medication + therapy follow up appointments):

$500.00 + ($500.00 x 25) = $13000.00

[ ] Adult patient (intake + monthly medication + therapy follow up appointments):

$500.00 + ($500.00 x 11) = $6000.00

By signing you acknowledge that you have received and understand the Good Faith Estimate above. This is not a contract.

Client name (please print): _____ Date: _____

Client name's signature: _____

Responsible party (please print): _____ Date: _____

Relationship between responsible party and client: _____

Responsible party name's signature: _____

Disclaimer:

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

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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 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 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 or call [1-877-696-6775].

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [1-877-696-6775].

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.

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