Good Faith Estimate Overview:

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" (GFE) of expected charges. The GFE shows the costs of items and services that are reasonably expected for services provided by ANV. The estimate is based on information known at the time the estimate was created. It does not take into account any reimbursement that you may receive as a result of out of network benefits. The GFE 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 you are billed for more than $400 above this Good Faith Estimate, you have the right to dispute the bill.

You may contact our business office and inform them that the billed charges are higher than the GFE. You can ask them to update the bill to match the GFE if the bill is more than $400 over the original GFE, or ask if there is financial assistance available.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-801-209-9797.

Live Life Well Counseling

Client Information:

Name:_____

Date of Birth:_____

Parent/Legal Guardian:_____

Primary Diagnosis:_____

IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed.

Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment.

It is within your rights to decline a formal diagnosis.

Provider Information:

Organization Name: Live Life Well Counseling

Facility NPI: 1417328030

Facility EIN: 462999281

Rendering Provider Name:_____

Rendering Provider NPI:_____

Office location where services are rendered: 376 E. 400 S. Suite #4 Springville, UT 84663 or online using a private and secure telehealth platform (therapyportal and/or doxy.me)

Services Provided at Live Life Well Counseling:

Service Code	Description	Rate

90791	Psychiatric Diagnostic Evaluation	$220
90837	Psychotherapy Session	$150
90847 or 90846	Family Therapy with or without the client	$175
90839	Crisis Therapy Session	$150
90853	Group Therapy	$35/hour
N/A	Letter/Revisions	$150/hour/$30 minimum

Estimated Services for :_____
(Based on weekly therapy appointments for 12 months)

Estimated Number of sessions	Service Code	Description	Rate	Estimated Total
1	90791	Psychiatric Diagnostic Evaluation	$220	$220
51	90837	Psychotherapy session (50-53 min)	$150	$7650

Total estimate of what you may owe:	**$7870**

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.

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 $400 above 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 HHS at (800)368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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.

By signing below or e-signing this document, I attest that I have received a copy of my Good Faith Estimate (GFE).

*Signature:*_____ *Date:*_____