*This document is provided as a good faith estimate of costs of services if you do not have insurance or coverage of my services:*

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

**Estimated Length of Services Provided:**  As determined by patient and the counselor due to clinical necessity.

**Estimated Type of Services Provided and Charges for each Service are as follows:**

90791, Initial Evaluation [Initial Session Only]:  $190.00

90837, Individual Counseling [All Sessions 53 minutes or more]: $160.00

90834, Individual Counseling [Follow up Sessions 38 to 52 minutes]: $160.00

90847, Family Psychotherapy [All Sessions Thereafter]: $160.00

Calls between sessions, Consultation, coordination of services, legal requests and/or reports are billed at the rate of individual sessions rate of $40.00 per 15 minutes, whether requested or required by client, courts, attorneys, medical professional, educational facility, or therapist.

Any additional recommended treatment will be offered on a separate estimate, such as emergency care. This is not a guarantee of treatment frequency, length, or cost. Your signature does not require you to receive psychotherapy services from me.

Financial statements will be provided to the client upon request at no additional fee.

The client is responsible for managing their own out-of-network or health savings account benefits.

The client is responsible for contacting their insurance company regarding the rules pertaining to their cost of in- or out-of-network services and processes required in filing claims with their insurance, such as pre-authorization requirements, CPT code coverage, annual limits and deductibles, and whether or not their insurance will provide coverage of services and how much the insurance company will pay for services. The provider will not be held financially responsible for the client’s failure to adequately research their benefits for these services. \*\*

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sherry Hubbard, LIMHP, MFT, PC

My signature below indicates that I have read, understand, and agree to upholding my responsibility as outlined in this document and am satisfied that the provider has been reasonably clear to the charges for services as outlined above.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*I would highly recommend that you call the 800# on the back of your insurance card for answers to these questions as the online answers to these questions on insurance company sites are often general in each of these areas and DO NOT necessarily apply to specific services with me.***

1. Am I covered for:
2. mental health outpatient services?
3. with Sherry Hubbard at Great Plains Counseling?
4. for codes 90791, 90837, 90847, 90834, 90846, and 90832?
5. Are there special billing requirements associated with these services?
6. Will in- or out-of-network reimbursement apply to these sessions?
7. What will I be responsible for paying? (Deductible and copayment for each session)
8. Are there any other financial limits on my policy regarding these sessions that I should know about?