Into the Light
Mental Health and Consulting Services, Inc.

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In compliance with the "No Surprises Act" that goes into effect January 1, 2022, all healthcare providers are required to notify clients of their right and protections against surprise costs associated with your healthcare. You have a right to receive notification when services are rendered by an out-of-network provider, if you are uninsured, or if you elect not to use your insurance. A Good Faith estimate is explaining how much your ESTIMATED Psychotherapy care will cost based on CURRENT symptoms as well as CURRENT rates. Note that this is an estimate only and subject to change based on change in symptoms or other life events. There may be additional items or services that are ethically recommend as part of the treatment that will be scheduled separately and are not reflected in the good faith estimate. Actual items, services, or charges may differ from the good faith estimate. The good faith estimate does not require you to obtain Psychotherapy or other services from this provider, and you are able to choose any provider of your choosing of your own free will. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill by using the resolution process by contacting this provider for a potential resolution or proceeding with a different resolution. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises .

Client Name **DOB**

Primary Diagnosis Code and Description, Secondary if applicable

Description and Code of Psychotherapy services to be furnished and expected cost

90791-Integrated Biopsychosocial Assessment	**$325**	One-time fee unless more than 3-month service lapse
90837-Individual Psychotherapy	**$300**	per 50-minute session
90847-Ongoing Couples Therapy	**$350**	per 50-minute session

An itemized list of items or services that are "reasonably expected" to be furnished;

Integrated Biopsychosocial Assessment _____1____
Individual sessions _____ weekly or _____ monthly Check here if ongoing services expected _x____
Couples session _____ weekly or _____ monthly Check here if ongoing services expected _____

Estimated One time Total for Assessment $250
Estimated Monthly Total varies depending on client choice as well as current symptoms
Estimated Yearly Total varies depending on client choice as well as current symptoms

I acknowledge that The Good Faith Estimate was explained to me and that I affirm that I have read and understand this form to the best of my ability.

_____ _____
Client Name Date