You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

Full Spectrum Counseling, PLLC

GOOD FAITH ESTIMATE FOR THERAPY SERVICES

Under Section 2799B-6 of the Public Health Service Act, the "No Surprises Act," you have a right to receive a "good faith estimate" explaining how much your therapy services will cost. Healthcare providers are required to provide clients who do not have insurance or who choose not to use their insurance for therapy services with an estimate of the cost of those services. The total cost for each client will vary depending upon the length of time and frequency of sessions that occur throughout the therapeutic relationship as determined by the initial assessment and continued evaluation of treatment needs and progress. A detailed list of possible services is provided below. This estimate will be valid for the next twelve (12) months. Should any fee changes occur, or upon your request, I/the practice will provide you with a new Good Faith estimate.

Client Information:

Client's Full Name: _____

Date of Birth: _____/_____/_____

Address: _____

City: _____ State: __ Zip: _____

Email Address: _____

Name of Legal Guardian* (if minor client): _____

Relationship to client: _____

Contact information, if different from above: _____

_____

Client Diagnosis:

Primary Service Requested/Scheduled: _____

Client Primary Diagnosis: _____

Primary Diagnosis Code: _____

Client Secondary Diagnosis: _____

Secondary Diagnosis Code: _____

Date of Scheduled Session/Appointment: _____

___ Check if Session/Appointment is not yet scheduled

Date of Good Faith Estimate: _____/_____/_____

Provider Information:

Provider Name and Type and State License No/s.: Rebecca Canter LPC-S #72456 & LCDC #13521

Phone Number: 512-761-6135

Email Address: Rebecca.fsctexas.life@gmail.com

National Provider Identifier (NPI): 1699420844

Employer Identification Number (EIN): 87-3808710

Details of Services/Items and Fees:

The following is a detailed list of expected charges for health care items and services scheduled for _____ (if scheduled), as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care. The estimated costs are valid for 12 months from the date of this estimate.

Service/Code: _____ Fee: _____

Service/Code: _____ Fee: _____

Service/Code: _____ Fee: _____

Service/Code: _____ Fee: _____

Total Estimated Cost for All Services:

Unless otherwise indicated the following services will be provided weekly for approximately one (1) year:

Services/Codes:_____

Total Estimated Cost: _____

Items and Services Requiring Separate Scheduling

Separate Good Faith Estimates will be issued upon scheduling or upon request of the following listed items and services. These items and services are expected to occur before or following the expected period of care for the primary item or service. For the items and services included in the following list, information such as diagnosis codes, services codes, expected charges and provider information do not need to be included at this time because that information will be provided in a separate Good Faith Estimate. Should you desire a Good Faith Estimate for these items or services, or wish to schedule these items or services, please let your provider or the practice know.

_____

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.

This 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 the bill.

Please note that this is only an estimate. Any services scheduled separately or in addition to the therapy services listed above are not reflected in this good faith estimate.

This estimate is not a contract and does not obligate you to obtain said services.

If you are billed for more than this Good Faith estimate, you have the right to dispute the bill.

You may contact your therapist or the practice to let them know the billed charges are higher than the Good Faith Estimate. You may 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.

If you dispute your bill, the therapist or practice cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the therapist or practice has to cease collection efforts. The therapist or practice must also suspend the accrual of any late fees on unpaid bill amount until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing the bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing the dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the therapist or practice, 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 1-800-958-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy or image of this Good Faith Estimate in a safe place. You may need it if you are billed a higher amount.

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Signature Date