GOOD FAITH ESTIMATE

SCHIRMER MENTAL HEALTH SERVICES

You are entitled to receive this "Good Faith Estimate" of what the charges could be for mental health services provided to you. While it is not possible for a mental health provider to know, in advance, how many psychotherapy and medication management sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of medication management and/or psychotherapy appointments you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services that may be recommended during treatment to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy and/or medication management appointments. The number of appointments that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your provider. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Pursuant to the No Surprises Act (HR133, Title 45 Section 149.610), this form is used to provide a current or prospective patient with a "Good Faith Estimate" (GFE) of expected charges for services to be provided. .

Patient Name:	Patient Date of Birth:
Patient Address:	
Patient Phone #:	Patient Email:
Diagnosis Codes (if known): Diagnosis will be continually evaluated throughout the course of treatment and cannot be appropriately provided at this moment.	
Services Requested (Type and Codes): 90792: Psychiatric Evaluation with Medical Services: 99214: Established Patient Outpatient Office Visit, 90833: Psychotherapy Add On	

Provider Name: Sarah Schirmer	License #: KY APRN 3011259
Provider Address: 1949 Goldsmith Ln. STE 103 Louisville, KY 40218	
Provider Phone #: 502-694-0441	
Provider Tax ID#: 86-3735241	Provider NPI #: 1912048133

The fee for a 60-minute psychiatric evaluation (in person or via telehealth) is $260. Most patients will attend one psychiatric evaluation visit at the start of their care. The fee for a 30-minute medication check is $80. The fee for a 60-minute psychotherapy and medication appointment is $135. The type of and frequency of appointments that are appropriate will be discussed with you at the start of your

care and depend upon your needs and provider clinical recommendations. Based on this per visit fee cited above, the following are some examples of yearly treatment plans and associated costs:

Treatment Plan Examples	Intensive Medication Management Only	Intensive Medication Management and Therapy	Maintenance Medication Management
Psychiatric Evaluation	$260	$260	$260
Med management	$80 x 1st 4 weeks = $320 $80 x every other week for 8 weeks = $320 $80 every 4 weeks for 38 weeks = $720		$80 every 12 weeks = $320
Med management and psychotherapy		$135 x 1st 4 weeks = $540 $135 x every other week for 8 weeks = $540 $135 x every 4 weeks for 38 weeks = $1215	
Total cost for one year	$1,620	$2555	$580

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.

You have a right to dispute a bill if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). Initiating the dispute process will not adversely affect the quality of services rendered to you. 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, 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. 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.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate: x/xx/xxxx

By signing below, I understand that my provider is providing a "good faith estimate" for the estimated costs associated with my mental health care.