Kairos Counseling Services

www.kairoscounselingservices.com • Tel. 610.995.2800

"No Surprises" Act | Good Faith Estimate

As of January 2022, laws regulating healthcare include the "No Surprises" act, entitling clients with no medical insurance or those who opt to go out-of-network to receive a Good Faith Estimate (GFE) for treatment costs anticipated in a 12-month time frame. Treatment from an in-network provider may cost less. Inquire with your insurance company regarding coverage options, and pre-authorization requirements. Out-of-network services may cost more either because you pay the full cost, or if submitting to your insurance may not result in services being applied toward your deductible or out-of-pocket limit. Unlike some medical services, the number of therapy sessions appropriate for a given client are difficult to know in advance, given variables involved. Total cost will be determined with your provider based on need, circumstantial factors, availability, and actual services rendered.

The Good Faith Estimate shows the costs of items and services reasonably expected for your care per item or service. It is not intended as a treatment recommendation, nor a prediction that you will necessarily need to attend a specified number of psychotherapy visits. You may discontinue treatment at any time. The GFE is not a contract, and does not obligate you to obtain services from the provider named; nor does it include any services rendered to you that are not identified here. The final cost of services may be different than the estimate, which is based on information known at the time created.

A new estimate for services beyond 12 months will be provided for continued services, and changes between the initial GFE and new GFE discussed. Clients should anticipate an increase in fees with each new GFE given cost of living changes, and a variety of expenses involved in the ability to offer professional services. Your therapist will indicate their current fees at the time of each new estimate:

Individuals: $_____ for Regular sessions (50-60min); $_____ initial Intake session (_____min)
Couples: $_____ for Regular sessions (50-60min); $_____ initial Intake session (_____min)
Families: $_____ for Regular sessions (50-60min); $_____ initial Intake session (_____min)

If a sliding scale is available for incomes that fall below a certain range, rates below may be used by providing proof of annual gross family income from a recent monthly paystub, W-2, or last tax return:

Under $_____subtract $____ from current rate | Under $_____subtract $____ from current rate

Client negotiated rate for: _____
$_____ from _____ to _____. [Subsequently, $_____ from _____ to _____.]

Disclaimers: The Good Faith Estimate does not include unknown, unexpected, or emergency-related costs that may arise during treatment; thus, you could be charged more if complications or special circumstances occur. There may be additional items or services recommended for your care that must be scheduled or requested separately, and therefore not reflected in this Good Faith Estimate. If the total amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate, (meaning $400 or more beyond the estimated charges), you may contact your health care provider 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; to negotiate the bill; or whether there is financial assistance available. You may also start a dispute resolution process with the US Department of Health and Human Services (HHS), if 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 pay the price on this Good Faith Estimate. If the agency disagrees with you, and agrees with the health care provider/facility, you will pay the higher amount. For more information about your right to a Good Faith Estimate, or the dispute resolution process, visit https://www.cms.gov/nosurprises/consumers, or call 1-800-985-3059. Initiation of patient-provider dispute resolution process will not adversely affect the quality of services rendered to you.

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Good Faith Estimate (cont'd)

Provider/Therapist Name: _____ | Phone #: 610.995.2800, Ext ____
Address: Kairos Counseling Services _____
Or, Provider Address: _____
Provider License: (PA) _____ | Tax ID#: _____ | NPI #: _____

Client Name: _____Date of Birth: _____
Date of Initial Session (if applicable): _____ Insurance: _____
Client Primary Diagnosis (and code, if applicable): _____
Services Requested: Psychotherapy or Counseling Services
Client Address: _____
Client Preferred Mode of Communication for GFE, if not in-person: Email:___ USMail:___ Other:_____
If Email, client initials to indicate they understand it is not a HIPAA approved method:_____
Date GFE requested (if applicable): _____ Date GFE provided:_____

A Good Faith Estimate that I can provide at this time, (to revise if needed—bottom of page)* :
From_____to_____, at $_____/session:
Depending progress, I estimate your care to entail _____ to _____ sessions if meeting [weekly/ every-other-week/monthly/quarterly], totaling [$_____ - $_____];
OR, _____ to _____ sessions if [weekly/every-other-week/semi-monthly/monthly/ quarterly], totaling [$_____ - $_____]. Variables of frequency, duration, or additional services not factored here.

From_____to_____, at $_____/session:
Depending progress, I estimate your care to entail _____ to _____ sessions if meeting [weekly/ every-other-week/monthly/quarterly], totaling [$_____ - $_____];
OR, _____ to _____ sessions if [weekly/every-other-week/semi-monthly/monthly/ quarterly], totaling [$_____ - $_____]. Variables of frequency, duration, or additional services not factored here.

Note: there is a likelihood that better outcomes may be linked with higher session frequency. Overestimating charges to account for some variability could be helpful as you budget your care. Therapy phone calls or other needed services would be additional.

Phone Calls: Outside of occasional scheduling purposes (generally less than 5 min), phone calls with clients between booked sessions are not usually anticipated. Calls requested by the client and/ or directly related to treatment in nature—(vs. scheduling or logistics)—are billed at $_____ for the first _____ minutes, and $_____ each additional minute, to be paid by (or before) subsequent appointments. (**Examples** are for illustrative purposes only, and do not necessarily pertain to your estimated treatment): up to 10min: $_____ | 15min: $_____ | 20min: $_____ | 25min: $_____

Provider: _____ Client(s) Sign: _____ Date____/____/202__

_____
***Revision to GFE:** Depending on the factors discussed, you may need between ____ and ____ more sessions this year than previously discussed. At $_____per visit, the total cost for this is estimated to be between $_____ and $_____.

Provider: _____ Client(s) Sign: _____ Date____/____/202__