CRAINE COUNSELING AND CONSULTING GROUP, LLC

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"NO SURPRISES ACT" GOOD FAITH ESTIMATE

For Clinical Social Workers

Provider Name ELLEN CRAINE	License/#: 6801061318
Provider Address: 31874 NORTHWESTERN HIGHWAY FARMINGTON HILLS, MICHIGAN 48334	
Provider Phone #: (248) 539-3850	
Provider Tax ID# (if applicable): 84-1875592	Provider NPI # (if applicable):

Patient Name:	Patient Date of Birth:
Patient Address (include if telehealth):	
Primary Diagnosis and Diagnosis Code *(if known/applicable; for new patients, 90791 Psychiatric Diagnostic Evaluation could be used)*	
Services Requested:	Date of Initial Session (if applicable):

You are entitled to receive this Good Faith Estimate of what the charges could be for (clinical social work) (psychotherapy) services provided to you. While it is not possible for a (clinical social worker) to know, in advance, how many (psychotherapy) 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 (psychotherapy) sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

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.

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 rendered to you that are not identified here.

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. There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately amd are not reflected in this Good Faith Estimate. 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 the right to initiate a dispute resolution process 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). 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 and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or 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. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

I anticipate your treatment will require [weekly/semi-monthly/monthly/quarterly] XX-minute psychotherapy sessions throughout the next 12 months at [X dollars] per session for a total of [x weeks] taking into consideration availability (reduce as appropriate for things like vacations, holidays, emergencies, sick time) for an estimated total of [fee per session] x [number of weeks]. Based upon a fee of $___150.00_____ per visit, if you attend one (psychotherapy) session per week, your estimated charge would be $___600.00_____for four visits provided over the course of one month; $__1200.00_____for eight visits over two months; or

$__1800.00_____for 12 visits over three months. If you attend (psychotherapy) for a longer period, your total estimated charges will increase according to the number of session and length of treatment.

I anticipate your treatment will require [weekly/semi-monthly/monthly/quarterly] 60-minute psychotherapy sessions throughout the next 12 months at [$150.00] per session for a total of [x weeks] taking into consideration availability (reduce as appropriate for things like vacations, holidays, emergencies, sick time) for an estimated total of [fee per session] x [number of weeks]. The fee for a 60-minute (psychotherapy) session (in person or via telehealth) is $__$150.00_____. This fee will be prorated according to the actual length of the session. In other words, if a session is only 30 minutes, the fee would be $75. Similarly, if the session goes over by 15 minutes or more, an additional prorated fee from the $150 will be added and expected to be paid at the time of the service. We will discuss the overage fee at the time it may be implemented so that you have the option of agreeing to pay these extra fees or ending the session within the 60-minute scheduled session. Based on a fee of $__150.00_____per 60- minute session, the following are expected charges:

Number of Weeks	Total estimated charges: 1 session per week	Total estimated charges: 2 sessions per week
1 Week of Service	$150	$300
13 Weeks of Service (Approx. 3 months)	$1950	$3900
26 Weeks of Service (Approx. 6 months)	$3900	$7800
39 Weeks of Service (Approx. 9 months)	$5850	$11,700
52 Weeks of Service (Approx. 12 Months)	$7800	$15,600

- Depending on the treatment plan we come up with, you may need between X to Y more sessions this year. At $150.00 per session and the estimated total costs are between X and Y [fee per visit times the number of sessions].
- Depending on the progress we make this year, I expect that you will need 10–20 more sessions this year. At $X per session the estimated total cost would be [10X–20X].

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 visits. The number of visits 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 therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

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: _____

Signature of Client Receiving this Estimate: _____

Signature of Social Worker providing this estimate: _____