



FEATHERLIGHT COUNSELING AND CONSULTATION LLC

*Helping you find your wings.*

Provider Name: FeatherLight Counseling and Consultation, LLC Jean Provance, LCSW, CCTP	Patient Name:
Provider License #: 44SC05473500	Patient Date of Birth:
Provider Address: 22 South Holmdel Drive, Suite 5 Holmdel, NJ 07744	Patient Address (include if telehealth):
Provider Phone #: (908) 510-0532	Primary Diagnosis and Diagnosis Code
Provider NPI #: 1457077646	Services Requested:
Provider Tax ID#: 92-0725891	Date of Initial Session:

You are entitled to receive this Good Faith Estimate of what the charges could be for clinical social work services- 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 and 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.

Number of Weeks of Psychotherapy	Total Estimate of Charges: 1 session per week	Total Estimate of Charges: 2 sessions per week
Initial Intake Assessment	\$250	-
1 week	\$175	\$300
13 weeks (approximately 3 months)	\$2,275	\$4,450
26 weeks (approximately 6 months)	\$4,450	\$9,100
39 weeks (approximately 9 months)	\$6,825	\$13,650
52 weeks (Approximately 12 months)	\$13,650	\$27,300

If you attend (psychotherapy) for a longer period, your total and estimated charges will increase according to the number of session and length of treatment.

If you are coming in for psychotherapy services and have mental health coverage from your insurance carrier- I am Out of Network, you are obligated to pay the fees up front and seek reimbursement from your insurance carrier. Out of Network coverage is not a guarantee that the services are going to be paid for by your plan or at what rate the insurance carrier will reimburse you. I will do my best to help you understand your individual coverage and the potential costs based on your plan. I will help you to seek the reimbursement but I am not responsible for denial of your claims.

\*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 sessions. 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.

Services Codes used:

90791- Diagnostic Interview with biopsychosocial assessment

90834- 48-52 minute psychotherapy session

90837- 60 minute psychotherapy session

90847- Psychotherapy for family with patient present

90846 Psychotherapy for family without patient present

90785- Interactive complexity (Play Therapy, EMDR)

90839- Crisis psychotherapy first 60 minutes

90840- Add on to crisis psychotherapy prolonged beyond 75 minutes

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_