Good Faith Estimate for Health Care Items and Services

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Email: _____

Primary Service or Item Requested/Scheduled:

- ☐ Testing/Assessment

Provisional Diagnosis: **Mental Disorder, not otherwise specified (F99)***

**The Good Faith Estimate requires a diagnosis code. This diagnosis will change after the intake session.*

If scheduled, list the date the Initial Service will be provided: _____

Date of Good Faith Estimate: _____ Total Estimated Cost: _____

The following page is a detailed list of expected charges. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Questions? Contact Kim Woodhouse (405)741-2844

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.

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

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.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

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.

Provider/Facility Estimate

Poyner Mental Health Services
14453 SE 29th, Suite D Choctaw, Oklahoma 73020
405-741-2844 • fax 405-733-1334
email poynermentalhealthservices@protonmail.com
National Provider Identifier 1740845361 • Tax Identification Number 83-4694411

Provider Name (National Provider Identifier):

- ☐ Gail Poyner, Ph.D. (1932141439)
- ☐ Kim Woodhouse, LPC (1114427267)
- ☐ Helen Allred, LPC (1508189465)

Details of Services and Items for Poyner Mental Health Services

☐ Testing/Assessment – Estimate for completion of assessments

Service Description	CPT Code	Price	Quantity	Expected Cost
Integrated biopsychosocial assessment, including history, mental status, and recommendations	90791	$175.00	1	$175.00
Psychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	96130	$175.00	1	$175.00
Each additional hour	96131	$175.00	11	$1,925.00
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 mins	96136	$87.50	1	$87.50
Each additional 30 mins	96137	$87.50	11	$962.50
Total				**$3,325.00**

I have read and understand the Good Faith Estimate for Health Care Items and Services.

Signature of Patient or Parent Printed Patient Name Date

Office Use Only

Date of Verbal Disclosure: Date of Email Disclosure:

Cash or Self-Pay Only

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

Under the law, health care providers need to give patients who don't have insurance or who are *not using insurance* an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.