



Fee Agreement & Good Faith Estimate Notification for Social-Emotional-Behavioral Healthcare

Hello!

Thank you so much for considering Meyer Therapeutics, PLLC for your social-emotional-behavioral needs. Below you will find a summary of services and their related fees paid directly to the provider, as Meyer Therapeutics, PLLC does not accept insurance at this time.

In compliance with the No Surprises Act that went into effect on January 1, 2022, healthcare consumers who do not have insurance or who are not using their insurance have a right to receive a Good Faith Estimate (GFE) for the total expected cost of any non-emergency medical items or services. The No Surprises Act also requires us to notify all healthcare consumers when services are rendered by a non-participating provider and provide options to receive care from an in-network provider if one is available. Please read the *Notice of Privacy Practices* to better understand your rights.

CPT	Description of Service - Therapist	Minutes/Hours	Fee
90791	Initial Assessment	90-120 Minutes	\$210
90832	Individual psychotherapy	<=37 Minutes	\$100
90834	Individual psychotherapy	38-52 Minutes	\$160
90837	Individual psychotherapy	53-60 Minutes	\$180
Phone Call	Therapist phone call	<5 Minutes	\$0
Phone Call	Therapist phone call	>5 Minutes	\$20
CNSLTGEN	Consult provided to potential client	60 Minutes	\$210
CONSULT	Clinical consultation to provider	60 Minutes	\$210
SCHVIS	School visit (charges accrue in 5 min intervals)	5 Minutes	\$20
90882	School/Agency/Community Conference (charges accrue in 5 min intervals)	5 Minutes	\$20
96101	Psychological testing (includes report writing and interpretation)	5-12 Hours	\$2,000
NSF	Check returned NSF	n/a	\$30
Missed/Cancel	Missed or cancelled appointment less than 24-hours before appointment	n/a	\$80

All home visits will follow the same fees and policies listed above and will include travel time. Clients will also be responsible for payment of any parking expenses incurred by the therapist/physician for home visits, school visits, and any other off-site appointments.

Meyer Therapeutics, PLLC is also required to provide you with a good faith estimate of the cost of services for the duration of treatment. It is difficult to determine the true length and nature of treatment for certain types of health care. Attached is the best estimate for **therapy services** based on what is most typical at Meyer Therapeutics, PLLC. This estimate is provided in an effort to be as transparent as possible about your potential financial investment in services at Meyer Therapeutics, PLLC. **Please read and sign the Financial Agreement and Good Faith Estimate which follow.**

Service Code	Description	Frequency	Cost	Total
90791	Initial Assessment (up to 120-minutes)	1x	\$210	\$210
90834	Individual Psychotherapy Session (50-minutes)	Weekly for 52-weeks	\$160 per 50-minute session	\$8,320
Phone Call	Consultation (> 5-minutes)	1-10 hours	Prorated fee based on \$160/hour	\$160 - \$1,600



You may incur fees throughout your care at Meyer Therapeutics, PLLC that are in addition to costs associated with direct services. These fees may occur due to the following (not an exhaustive list):

- Late cancellation/no show fee
- Medical records request
- Completion of documents (FMLA, disability, summary letters, etc.)
- Consultation/Case Management (IEP meetings, coordination of care, etc.)
- Subpoena & Court Orders (request to testify)

Please review the *Practice Policies and Informed Consent for Treatment* for additional information on these services.



Financial Agreement

- I understand that Lauren Meyer, PhD, LP, NCSP does not accept insurance.
- I acknowledge that an intake session is \$210 (90-minutes to 2-hours) and each follow-up session is \$160 (50-minutes).
- I understand that by taking part in any group, if applicable, I am contracting for a reserved place in the group, and that payment is expected regardless of attendance.
- I understand that Lauren Meyer, PhD, LP, NCSP can provide a superbill, which will require diagnosis, that I can submit to my insurance. I understand that not all superbill claims are reimbursed.
- I understand that understanding my insurance company's out-of-network benefits is my responsibility.
- I acknowledge that full payment is due at the time of service.
- I understand that any phone conversation over 5 minutes will be charged at a prorated fee based on \$160/hour.
- I understand that any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time, will be charged an \$80 fee. Generally, the first cancellation fee is waived.
- I authorize Lauren Meyer, PhD, LP, NCSP to charge my card, which will be kept on file using secure systems, for office charges.
- I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.
- I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due & paid in full.
- I acknowledge that credit card transactions could be linked to Protected Health Information.
- I understand that there will be a monthly service charge of 0.75% of any unpaid fees (9%/year), and that balances not paid in a timely manner may be turned over to an independent agency for collection.

Client Name

Printed Name of Card Holder/Responsible Party

Signature of Card Holder/Responsible Party and Date



Good Faith Estimate Acknowledgment

- I/We acknowledge reviewing the above information, and have had the opportunity to ask whatever questions necessary for clarification. I understand that I will be charged for services at Meyer Therapeutics, PLLC, according to the fees listed above. I understand that I am responsible for all fees, regardless of whether my insurance pays for services, and I agree to make payments at the time service is provided.
- I understand I am giving up some consumer billing protections under federal law following the No Surprises Act.
- I understand I was given this written notice explaining that my provider or facility is not in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I understand can end this agreement by notifying the provider or facility in writing before getting services.
- By signing, I give up my federal consumer protections and agree to pay more for out-of-network care. With my signature, I am saying that I agree to receive the items or services from Dr. Lauren Meyer.

IMPORTANT: You are NOT required to sign this form. If you do not sign, however, Dr. Meyer may not be able to treat you. You can choose to receive care from a provider or facility in your health plan's network.

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.

Client Name

Printed Name of Card Holder/Responsible Party

Signature of Card Holder/Responsible Party and Date

Please take a photo and/or keep a copy of this document. It contains important information about your rights and protections.