Client 1:
Client 2:
Provider: Robin K. Schnitzler
Provider License: LMFT #2074-124

Good Faith Estimate, Disclaimer, & Waiver - 6/1/23

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GOOD FAITH ESTIMATE, DISCLAIMER, & WAIVER

CLIENT INFORMATION

Full Name:

Birthdate:

Complete Mailing Address:

Best Phone Number:

Best Email:

PRACTICE AND PROVIDER INFORMATION

Relationship Therapy of Madison, LLC
Robin K. Schnitzler, LMFT
2564 Branch Street, Suite B5
Middleton, WI 53562
(608) 284-8865
info@relationshiptherapymadison.com
WI State licensure #2074-124
NPI#1710430335

GOOD FAITH ESTIMATE AND DISCLAIMER

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

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The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental 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.

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You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you..While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, 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 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.

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GOOD FAITH ESTIMATE (OF EXPECTED COSTS)

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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.

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Typically, couples attend therapy every-other-week; some couples attend sessions more frequently in order to address their needs. Regardless of frequency, a session for couples is:
75 minutes and costs $195 per session (CPT 90847).

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Typically, individuals attend therapy weekly; some individuals attend less frequently. Regardless of frequency, a session for an individuals is:
50 minutes and costs $130 per session (CPT 90834).

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Relationship Therapy of Madison recognizes every client's therapy journey is unique. How long you engage in therapy and how often you attend sessions will be influenced by many factors including:

- *Your schedule and life circumstances*
- *Therapist availability*
- *Ongoing life challenges*
- *The nature of your specific challenges and how you address them*
- *Personal finances*

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You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge.

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While the length of service varies, for the purpose of this estimate we assume 12 months of treatment. If you wish, you can project your own total estimated cost by multiplying the number of sessions you plan to attend over a 12 month period by your session cost, which will result in the total estimated cost for your services. For example, if you have 2 sessions per month over 12 months then your cost would be [session fee] x [24 sessions].

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The frequency of your psychotherapy visits may be more or less than what is stated above, depending upon your individual needs and preference. It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time.

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Rates will increase periodically, no more than one time per year; you will receive a minimum of 60 days notice of any cost increase. At the time of a rate increase, a new Good Faith Estimate will be provided.

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If you do obtain therapy services (CPT 90847 or 90834) from Relationship Therapy of Madison, you will be billed separately for each session; an invoice for the amount of one session is created immediately after each session, and it is paid using your credit card on file.

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DISCLAIMER

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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. Your provider may recommend additional services that are not reflected in this Good Faith Estimate. For example, clients may choose to attend a recommended group. The information provided in the good faith estimate is only an estimate and actual items, services, or charges may differ from the good faith estimate.

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Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events.You could be charged more if complications or special circumstances occur. Other potential items and/or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items/services and associated fee(s) are discussed further within the Informed Consent documentation and should these items/services be initiated a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

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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.

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You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS) if you receive a bill that is at least $400 more than your Good Faith Estimate. 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.

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For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059.

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Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.

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You may need it if you are billed a higher amount. (disclaimer pursuant of CMS form for 10791)

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With my signature for this Good Faith Estimate, I acknowledge that I am not obligated or required to obtain any of the listed services from this provider and that I am consenting of my own free will, free from coercion or pressure. I also understand that:
• I was given notice explaining the estimated costs of services, and what I may owe if I agree to be treated by this practice.
• I am giving up some consumer billing protections under federal law.
• I agree to pay for out-of-network care at the rates provided in this Good Faith Estimate..
• I have received notice both verbally and written/electronically.

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IMPORTANT: You are not required to sign this form; however, if you do not sign, the provider and/ or practice may not treat you. You have the right to choose to get care from a provider and/or practice that is within your health plan's network.

Client Signature:

Date:

INSURANCE WAIVER

It is your right to chose, instead, to work with a mental health provider within your insurance company's network. Those amounts may or may not be less than the fees you are agreeing to pay Robin K. Schnitzler.

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By signing this consent form, I understand that:
• This practice does not accept insurance as a method of payment.
• I am waiving use of my insurance benefits for services provided by this practice.
• I agree to out-of-network care.
• I am opting out of both in-network and out-of-network benefits.

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As such, I understand that:
• Any and all amounts that I pay to Relationship Therapy of Madison will NOT count towards my health plan's deductible, co-pay, co-insurance, or out-of-pocket limit, and;
• I will not be provided superbills.

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I have read, understand, and consent to treatment at Relationship Therapy of Madison and acknowledge that I will self-pay for services rendered by Robin K. Schnitzler.

Client Signature:

Date:

YOU ARE ENTITLED TO SELECT HOW YOU RECEIVE THIS GOOD FAITH ESTIMATE.

After you complete this form, you can access it from the portal:
- You may print a hard copy for your records.
- You may save a copy to your computer.

Please indicate one choice:

- I also want it emailed to me.