Patient Information

Patient

First name:

Middle name:

Last name:

Date of birth:

Patient Contact Information

Street or PO box:

City, state, ZIP:

Phone number:

Email address:

Patient's contact preference:

Patient Diagnosis

Primary service or item requested/scheduled:

Patient primary diagnosis:

Patient secondary diagnosis:

If scheduled, list the date(s) the Primary Service or Item will be provided:

Date of good faith estimate:

Provider Information

Provider name: Whole House Counseling & Consultation
Provider/facility type: Group Practice
Street address: 855 Cannes Ct.
City: Loveland
State: OH
ZIP code: 45140
Contact person: Stephanie Rhodes
Phone: (513) 813-6415
Email: info@wholehouseconsultation.com
National Provider Identifier (NPI): 1336632199
Taxpayer Identification Number (TIN): 83-0809320

Details of Services and Items for Whole House Counseling & Consultation

The following is a detailed list of charges at Whole House Counseling & Consultation. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Provider Estimates - *Maximum does not include late cancelation/no show fees, crisis sessions, non-therapeutic charges. See 'Practice Policies, Disclosure, and Financial Responsibility' for complete details regarding this fee schedule.

Psychotherapy:

90791~ Beginning Assessment - $250.00
90837~ Individual Psychotherapy, 53 - 60 minutes - $200.00
90839 ~ Psychotherapy Crisis, Additional 60 minutes - $125.00
90840 ~ Psychotherapy Crisis, Additional 30 minutes - $75.00
90846 ~ Family Psychotherapy, w/o patient present - $250.00
90847 ~ Family Psychotherapy, w/ patient present - $250.00

Whole House Counseling & Consultation estimated total intake fee*:

~Intake Session Fee: $250.00

Whole House Counseling & Consultation estimated total for weekly sessions*:

~Individual Weekly Session Fee: $200.00
~Couple/Family Weekly Session Fee: $250.00

Total estimated psychotherapy cost*:

~Individual Annual Fee: Maximum $10,450.00*
(based on 51weeks x $200.00+250.00 = $10,450.00)

~Couple/Family Annual Session Fee: Maximum $13,000.00*
(based on 52weeks x $250.00 = $13,000.00)

Length of Services

Psychotherapy services can range from two days, to two months, to a year or more. The length of time you will need to be in therapy is based on your therapeutic goals, your overall wants and needs, and any psychosocial/financial barriers that may arise. With that being said, communication is key to any healthy relationship. Should a financial hardship occur, you are encouraged to discuss your situation with Whole House Counseling & Consultation to determine the best resolution as it pertains to your continuity of care and the therapeutic relationship.

Should more time be required to meet your therapeutic goals, we will discuss your options with you at which time a new Good Faith Estimate will be created, your therapeutic services will end, or you are referred to another provider.

The above listed total estimated psychotherapy cost is based on a 52 week structure at the individual rate of $200.00 per one session a week and intake fee of $250.00 and the couples/families rate of $250.00 per one session a week and intake fee of $250.00. It is based solely on our out of pocket rate and DOES NOT take into consideration insurance or HSA/FSA benefits. These benefits could lower your out of pocket costs significantly. Please note, these totals also DO NOT account for no show/late cancelation fees, crisis sessions, non-therapeutic charges or other financial arrangements based on a case-by-case basis. You are encouraged to carefully read the Practice Policies, Disclosure, and Financial Responsibility forms for complete details regarding fee schedule.

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 or call HHS at (800) 368-1019.

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) 368-1019.

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.

Estimate

This estimate DOES NOT account for no show/late cancelation fees, crisis sessions, non-therapeutic charges or other financial arrangements based on a case-by-case basis. You are encouraged to carefully read the Practice Policies, Disclosure, and Financial Responsibility forms for complete details regarding fee schedule.

1.

Service/item:

Address where service/item will be provided [street, city, state, ZIP]:

Diagnosis code [ICD-10]:

Service code [service code type: service code number]:

Quantity:

Expected cost [for this service only]

2.

Service/item:

Address where service/item will be provided [street, city, state, ZIP]:

Diagnosis code [ICD-10]:

Service code [service code type: service code number]:

Quantity:

Expected cost:

3.

Service/item:

Address where service/item will be provided [street, city, state, ZIP]:

Diagnosis code [ICD-10]:

Service code [service code type: service code number]:

Quantity:

Expected cost:

Total Expected Charges from Whole House Counseling & Consultation:

Additional health care provider/facility notes: