EMOTIONAL ARCHITECT, LTD
TRAUMA THERAPY

Good Faith Estimate for Health Care Items and Services

General Information
Provider Name & NPI: Emotional Architect Ltd. 1255875936
Tax ID Number: 81-4525778

Client name: _____ Client DOB: _____

Services will be provided at the following location:

- ☐ 4201 N. Damen Avenue
  Chicago, IL 60618
- ☐ Telehealth

Client Sessions

- ☐ Individual Therapy ($150.00)
- ☐ Family Therapy ($150.00)
- ☐ Other: _____

Diagnosis Code (If known): _____

- ☐ Client declines to receive a formal diagnosis at this time.

Date of Good Faith Estimate: _____/_____/_____

Total estimated cost for one year of services:

- ☐ Weekly ($150.00 x 52) **$7800.00**
- ☐ Bi-Weekly ($150.00 x 26) **$3900.00**
- ☐ Monthly ($150.00 x 12) **$1800.00**
- ☐ Other: _____

By signing you acknowledge that you have received and understand the Good Faith Estimate above. This is not a contract.

_____ (Printed Name) _____ (Relationship To Client)

_____ (Signature) _____ (Date)

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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. Please be advised, your fee may change depending on the number of sessions you actually attend. Services outside of standard therapy may have an associated extra cost. Please refer to our Practice Policies for a complete list of fees and services.

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 healthcare 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.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

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.

I have received and understand the Good Faith Estimate Disclaimer above:

_____ (Printed Name) _____ (Relationship To Client)

_____ (Signature) _____ (Date)

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STANDARD SESSION FEES

- Individual (50 minutes) $150
- Family (50 minutes) $150
- Letter/Report Writings $125/hr
- Records Requests/Administrative Costs $30.00
- A $30.00 service charge will be charged for any checks returned for any reason for special handling.
- ***The insurance rate will be accepted for clients whose insurance our practice accepts.

Court Action/Legal Fees –

- Preparation time (including submission of records): $200/hr.
- Phone calls/Emails: $200/hr.
- Depositions/Court Hearings: $375/hr
- Consultation with other professionals: $200/hr
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- The minimum charge for a court appearance: $1500 (additional charges will incur if court is more than 4 hours).

Immigration Assessment

- Extreme Hardship $650
- Victim of a Crime $650
- Domestic Violence $650
- Asylum $1400

Additional Fees

- Returned Check Fee- $35.00
- Collections- 25% Fee