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Good Faith Estimate

The *No Surprises Act of 2022* requires that healthcare providers give their patients a Good Faith Estimate of service costs for the coming year. *This is an estimate only*. Actual costs may be more or less than the amount listed on this form. The present law requires that a Good Faith Estimate be given to the following patients:

1. Patients who do NOT have health insurance of any kind, (i.e., commercial insurance, HMOs, union health plans or government health plans.)
2. Patients who DO have health insurance that would pay for all or part of their treatment, but who DECLINE to use their insurance for the cost of their treatment.
3. Patients who are shopping for care.

Please fill out and sign below indicating which category you fall into. If you fall into Category B, you will be provided a Good Faith Estimate of fees for the current year prior to your first session. The estimate will be filled in on this form, which will be returned to you.

A. I plan to use my insurance to pay for all or part of my mental health treatment with Christa Jallorina Christian Counseling, LLC. My copay is _____ per session. My health insurance is through _____. (name of company)

   Client Name (printed): _____

   Client Signature:_____ Date: _____

B. I do not have health insurance of any kind, am just shopping for services or I do not plan to use the health insurance I have. **I plan to pay out of pocket for my treatment**.

   Client Name (printed): _____

   Client Signature:_____ Date:_____

   To be Filled out by Therapist:

   Your Out of Pocket fee per session is: _____. (See *Fee Disclosure Sheet* for more details on fees). I understand that if I attend counseling _____ (times per month) for one year, the total cost for this year would be about:_____.

   Therapist Signature: _____Date:_____
   Christa Jallorina, LCSW

   Date Estimate Returned to Client:_____