Dear Valued Client,

In compliance with the No Surprises Act that went into effect on January 1, 2022, healthcare consumers who don't have insurance or who are not using their insurance have a right to receive a Good Faith Estimate 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 Disclosure Notice Regarding Patient Protections to better understand your rights.

Additionally, we are 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 our best estimate based on what is most typical at Intuition Wellness Center. ***Please read and sign the Good Faith Estimate which follows.*** *This estimate is provided in an effort to be as transparent as possible about your potential financial investment in services at Intuition Wellness Center.*

You may incur fees throughout your care at Intuition Wellness Center 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)*

For a complete list of fees, please see our online** Pricing Schedule**.

Intuition Wellness Center
5675 N Oracle Road, Suite 3101
Tucson, AZ 85704
EIN: 46-1623524
NPI: 1053657841

intuition
wellness center
intuitionwellness.com

Good Faith Estimate

Client Name: _____ Date of Birth: _____
Primary Diagnosis and Diagnostic Code: To be determined; fee per service will remain the same regardless of diagnosis.

Occupational Therapy Clients

Service Code	***Description***	***Frequency***	***Cost***	***Total***
	Evaluation Intake	*1-2x*	*$200-$250 per unit (based on client age)*	*$200-$500*
	Feedback Session w/ Follow-up Treatment	*1x*	*$85 per session*	*$85*
	OT Treatment	*1-2x weekly for 52 weeks*	*$85 per session*	*$4,420-$8,840*
	Case Management	*1-10x*	*$10.63 per 15 min*	*$10.63-$106.30*
	Re-Evaluation	*1x*	*$150*	*$150*
			Total Estimate:	*$4,865.63-$9,681.30*

***See Schedule of Fees for additional costs of services.*

Call your health plan. *If you have additional questions regarding your anticipated out-of-pocket costs or cost-sharing benefits please contact your health insurance plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.*

Questions about this notice and estimate? *Call Intuition Wellness Center's Billing department at (520) 333-3320 or email contact@intuitionwellness.com.*

More information about your rights and protections*: Visit https://www.cms.gov/nosurprises for more information about your rights under federal law. You can also contact the Department of Health and Human Services with questions.*

intuition
wellness center
intuitionwellness.com

Understand your options. *You can also get the items or services described in this notice from providers who are in-network with your health plan. Intuition Wellness will give you in-network referral information if possible. Following is the Intuition Wellness Provider and their NPI and insurance status:*

Clinician	***BCBSAZ***	***Any Other***
Anne Berkery, OTR/L *Occupational Therapist* *NPI: 1558491662*	*In Network*	*Out of Network*

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 get the items or services from (select):

[ ] Anne Berkery, OTR/L

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

- *I'm giving up some consumer billing protections under federal law.*
- *I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.*
- *I was given written notice on _____ explaining that my provider or facility isn't 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 got the notice either on paper or electronically, consistent with my choice.*
- *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 can end this agreement by notifying the provider or facility in writing before getting services.*
- ***IMPORTANT:*** *You* ***don't*** *have to sign this form. But if you don't sign, this provider and Intuition Wellness might not be able to treat you. You can choose to get care from a provider or facility in your health plan's network.*

Client/Guardian Printed Name *Signature of Client /Guardian* *Date/Time of Signature*

Additional Guardian Printed Name *Signature of Guardian* *Date/Time of Signature*

Take a picture and/or keep a copy of this form. It contains important information about your rights and protections.

intuition
wellness center
intuitionwellness.com