Dear Valued Client,

In compliance with the No Surprises Act that went into effect on January 1, 2022, healthcare consumers who do not 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 Patron 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 healthcare. Attached is our best estimate based on what is most typical at Intuition Wellness Center. ***Please read the Good Faith Estimate which follows; complete, sign and date all highlighted areas on page 6.*** *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 lists):

- *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 Fee Schedule.

Please take a photo and/or keep a copy of this document. It contains important information about your rights and protections.

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

GOOD FAITH ESTIMATE

Counseling & Psychological Testing

Primary Diagnosis/Diagnostic Code: To be determined; fee per service will remain the same regardless of diagnosis.

Fee Schedule A: Counseling Clients (Independently Licensed Provider)

Service Code	Description	Frequency	Cost	Total
90791	Diagnostic Intake	1-2x	$200 per unit	$200-$400
90837/90846/ 90847	Individual/Couples/ Family Therapy	Weekly for 52 weeks	$165 per 60min session	$8,580
90846	Parent Support Session (only applies to caregivers of individual clients)	Monthly for 10-12 months	$165 per 60min session	$1,650-$1,980 (only applies to caregivers of individual clients)
T1016	Case Management/ Consultation	1-10x	$41.25 per 15min	$41.25-$412.50
			Total Estimate:	**$10,471.25-$11,372.50**

*See Fee Schedule for additional costs of services.

Fee Schedule B: Counseling Clients (Supervised Post-Doctoral Fellow or Therapist Seeking Higher Licensure)

Service Code	Description	Frequency	Cost	Total
90791	Diagnostic Intake	1-2x	$150 per unit	$150-$300
90837/90846	Individual Therapy/ Parent Support Session	Weekly for 52 weeks	$100 per 60min session	$5,200
90846	Parent Support Session (only applies to caregivers of individual clients and in absence of weekly sessions)	Monthly for 10-12 months;	$100 per 60min session	$1,000-$1,200 (only applies to caregivers of individual clients and in absence of weekly sessions)
T1016	Case Management/ Consultation	1-10x	$25 per 15min	$25-$250
			Total Estimate:	**$6,375-$6,950**

*See Fee Schedule for additional costs of services.

Fee Schedule C: Counseling Clients (Supervised Psychology Extern)

Service Code	Description	Frequency	Cost	Total
90791	*Diagnostic Intake*	*1-2x*	*$100 per unit*	*$100-$200*
90837	*Individual Therapy*	*Weekly for 52 weeks*	*$75 per 60min session*	*$3,900*
90846	*Parent Support Session*	*Monthly for 10-12 months*	*$75 per 60min session*	*$750-$900*
T1016	*Case Management/ Consultation*	*1-10x*	*$18.75 per 15min*	*$18.75-$187.50*
			Total Estimate:	***$4,768.75-$5,187.50***

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

Fee Schedule D: Psychological Testing Clients (Independently Licensed Psychologist)

Service	Description	Frequency	Cost	Total
90791	*Diagnostic Intake*	*1-2x*	*$200 per unit*	*$200-$400*
96130/96131 96136/96137	*Assessment Administration*	*4-6 hours*	*$200 per 60min*	*$800-$1,200*
96130/96131 96132/96133	*Scoring, Interpretation & Report Writing*	*2-6 hours*	*$200 per 60min*	*$400-$1,200*
96130/96131	*Feedback*	*1-2x*	*$200 per 60min*	*$200-$400*
			Total Estimate:	***$1,600-$3,200*****

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

***The above testing estimate is based on a full and comprehensive battery of tests. Diagnostic Intake fee is due on day of service. A deposit of $1400 is due on the date testing assessment begins. The remaining balance is due at the time of the feedback appointment when a final report and results are given. In instances when a partial and/or limited assessment is recommended by the provider the deposit may be reduced.*

Fee Schedule E: Psychological Testing Clients (Supervised Psychology Post-Doctoral Fellow)

Service	Description	Frequency	Cost	Total
90791	Diagnostic Intake	1-2x	$150 per unit	$150-$300
96130/96131 96138/96139	Assessment Administration	4-6 hours	$150 per 60min	$600-$900
96130/96131 96138/96139	Scoring, Interpretation & Report Writing	2-6 hours	$150 per 60min	$300-$900
96130/96131	Feedback	1-2x	$150 per 60min	$150-$300
			Total Estimate:	**$1,200-$2,400****

*See Fee Schedule for additional costs of services.
**The above testing estimate is based on a full and comprehensive battery of tests. Diagnostic Intake fee is due on day of service. A deposit of $1000 is due on the date testing assessment begins. The remaining balance is due at the time of the feedback appointment when a final report and results are given. In instances when a partial and/or limited assessment is recommended by the provider the deposit may be reduced.

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 can also ask about what is covered under your plan and your provider options.

Questions about this notice and estimate? Call Intuition Wellness Center's Billing Department at 520-419-4740 or email contact@intuitionwellness.com.

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

Understand your options. You can also receive 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 a list of Intuition Wellness Counseling and Psychological Testing providers, their assigned Fee Schedule, NPI and insurance status:

Provider	BCBSAZ	Aetna	Any Other
Monica Arriaga, LCSW **Fee Schedule A pg. 1** Child & Family Therapist NPI: 1942948153	Out of Network	Out of Network	Out of Network
Brandy Baker, PsyD **Fee Schedule A pg. 1** Clinical Psychologist NPI: 1609178250	In Network	In Network	Out of Network
Amy Cormode, LAC **Fee Schedule B pg. 1** Child & Family Therapist (Supervised; Seeking higher licensure) NPI: 1013627876 *Supervisor: Brandy Baker, PsyD	Out of Network	Out of Network	Out of Network
Elaina Espinosa, BS, Psychology Extern (Supervised) *Supervisor: Brandy Baker, PsyD **Fee Schedule C pg. 3**	Out of Network	Out of Network	Out of Network
Allison Fairchild, PhD, Post-Doctoral Fellow Child & Family Therapist **Fee Schedules B pg. 1/E pg. 4** (Supervised; Seeking licensure) NPI: 1770266587 *Supervisor: Brandy Baker, PsyD (Counseling) *Supervisor: Emery Mahoney, PhD, NCSP (Testing)	Out of Network	Out of Network	Out of Network
Heather Finn, LCSW **Fee Schedule A pg. 1** Child & Family Therapist NPI: 1619143070	Out of Network	Out of Network	Out of Network
Sherrill Koogler, LCSW, RPT-S **Fee Schedule A pg. 1** Child & Family Therapist NPI: 1487872727	In Network	In Network	Out of Network
Emery Mahoney, PhD, NCSP **Fee Schedule D pg. 3** Psychologist NPI: 1619538816	Out of Network	Out of Network	Out of Network
Yoendry Torres, PsyD **Fee Schedule A pg. 1** Clinical Psychologist NPI: 1588966022	Out of Network	Out of Network	Out of Network
Carolyn Tureaud, MA, Psychology Extern (Supervised) *Supervisor: Brandy Baker, PsyD **Fee Schedule C pg. 3**	Out of Network	Out of Network	Out of Network
Debra "Debby" Urken, LCSW **Fee Schedule A pg. 1** Child & Family Therapist NPI: 1245852672	Out of Network	Out of Network	Out of Network
Nadia Zanger, LMFT **Fee Schedule A pg. 1** Child & Family Therapist NPI: 1841699899	Out of Network	Out of Network	Out of Network

Client Name: ____ **Date of Birth:** ________________________

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 receive the items or services from (select all providers who apply):

Monica Arriaga, LCSW	*Counseling Clients*	*Fee Schedule A*
Brandy Baker, PsyD	*Counseling Clients*	*Fee Schedule A*
**Amy Cormode, LAC*	*Counseling Clients*	*Fee Schedule B*
**Elaina Espinosa, BS*	*Counseling Clients*	*Fee Schedule C*
**Allison Fairchild, PhD, Post-Doctoral Fellow*	*Counseling/Testing Clients*	*Fee Schedules B & E*
Heather Finn, LCSW	*Counseling Clients*	*Fee Schedule A*
Sherrill Koogler, LCSW, RPT-S	*Counseling Clients*	*Fee Schedule A*
Emery Mahoney, PhD, NCSP	*Testing Clients*	*Fee Schedule D*
Yoendry Torres, PsyD	*Counseling Clients*	*Fee Schedule A*
**Carolyn Tureaud, MA*	*Counseling Clients*	*Fee Schedule C*
Debra "Debby" Urken, LCSW	*Counseling Clients*	*Fee Schedule A*
Nadia Zanger, LMFT	*Counseling Clients*	*Fee Schedule A*

****Supervisor's Name & NPI:** **(Refer to page 5; required)***	*Brandy Baker, PsyD NPI: 1609178250*	*Emery Mahoney, PhD, NCSP NPI: 1619538816*	*N/A*

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 am giving up some consumer billing protections under federal law.*
- *I may receive 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 **(date received)** ______________ explaining that my provider or facility is not 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 received 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 receiving services.*

***IMPORTANT:** You do not have to sign this form. But if you do not sign, the provider(s) and Intuition Wellness Center may not be able to treat you. You can choose to receive care from a provider or facility in your health plan's network.*

I UNDERSTAND THAT MY TYPED NAME BELOW IN THE SIGNATURE LINE REPRESENTS MY ELECTRONIC SIGNATURE.

Relationship to Client: *Self* *Parent* *Guardian*

____
Client or Parent/Guardian Printed Name

____
Client or Parent/Guardian Signature

____
Date/Time of Signature

Relationship to Client: *Parent* *Guardian*

____
Additional Parent/Guardian Printed Name

____
Additional Parent/Guardian Signature

____
Date/Time of Signature