

Dear Valued Client,

In compliance with the No Surprises Act (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 clinical 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. This estimate is provided in an effort to be as transparent as possible about your potential financial investment in psychiatric clinical services at Intuition Wellness Center. **Please review the Good Faith Estimate which follows and complete requested information in the highlighted areas on page 3.**

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, refer to our online [Pricing Schedule](#).

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 is covered under your plan and your provider options.

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

More information about your rights and protections. Visit cms.gov/nosurprises for 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 clinicians who are in-network with your health plan. Intuition Wellness will give you in-network referral information if possible.

[Intuition Wellness Center](#)

3131 N Country Club Rd, Ste 207

Tucson, AZ 85716

EIN: 46-1623524

NPI: 1053657841

Good Faith Estimate *Psychiatric Clinical Services*

Clinical Team Member	Insurance Status
Lori Harger, Psych NP Psychiatric Nurse Practitioner NPI: 1831444710	Out-of-Network

Psychiatric Clinical Clients

Primary Diagnosis and Diagnostic Code:

To be determined; for self pay clients, fee per service will remain the same regardless of diagnosis.

Service Code	Description	Frequency	Cost	Total
90792	Intake-Initial Visit 90 min	1x	\$300	\$300
99215	Follow-Up Visit 60 min	1-12x per year	\$200 per visit	\$200-\$2,400
99214	Follow-Up Visit 30 min	1-2x per year	\$150 per visit	\$150-\$300
T10106	Case Management	1-2x per year	\$25 per 15-min increment	\$25-\$50
Expedited Prescription Request	Expedite Fee	1x per year	\$30 per request	\$30
			Total Estimate:	\$705.00-\$3,080.00

*See [Fee Schedule](#) for additional service costs.

Client Name: _____ **Client 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:

Lori Harger, Psych NP, Psychiatric Nurse Practitioner

Your signature(s) below acknowledges your understanding that you:

- are consenting of your own free will and are not being coerced or pressured;
- are giving up some consumer billing protections under federal law;
- may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under your health plan;
- were **initially** given written notice via email or hard copy on _____, explaining
received date
that your clinician or facility is not in your health plan's network, the estimated cost of services, and what you may owe if you agree to be treated by this clinician or facility;
- received the notice either on paper or electronically, consistent with your choice;
- fully and completely understand that some or all amounts you pay might not count toward your health plan's deductible or out-of-pocket limit; and,
- can end this agreement by notifying the clinician or facility in writing before receiving services.

Important: You do not have to sign this form. But if you do not sign, this clinician and Intuition Wellness might not be able to treat you. You can choose to get care from a clinician or facility in your health plan's network. This document includes important information about your rights and protections. Please keep a copy or take a photo for your records.

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

In the case of a minor, all parents/guardians are required to print name, sign, date with time, and complete highlighted areas on page 3 for receipt of Good Faith Estimate to be valid.

Relationship to Client: Self Parent Guardian

Relationship to Client: Parent Guardian

Client or Parent/Guardian Printed Name

Additional Parent/Guardian Printed Name

Client or Parent/Guardian Signature

Additional Parent/Guardian Signature

Date

Date

Time

Time