**Jes James Sellers, PhD**

Licensed Psychologist Ohio 3529

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**Good Faith Estimate (GFE) for Health Care Items and Services**

Due to the nature of mental health treatment, the number of total sessions in the treatment is unknown at the outset and is based on your needs, preferences, and the progress made in the treatment. A GFE is good for 12 months, unless circumstances change. At the end of 12 months, I will issue a new GFE.

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| **Patient** |
| First Name Middle Name Last Name |
| Patient Date of Birth: |
|  |
| **Patient Mailing Address, Phone Number, and Email Address** |
|  |
| City State Apartment ZIP Code |
| Phone |
| Email Address |
| Primary Service - requested/scheduled, e.g., initial assessment, psychotherapy session, etc. |
| Anticipated number of treatment sessions - presented to the client after initial assessment |
| Date of Good Faith Estimate (GFE) |
| Total Estimated Cost -the number of sessions multiplied by the ongoing session fee. |

The following is a detailed list of charges for my professional services that also appear on my website. You will be responsible for directly paying me, unless you are using a health insurance plan in which I am designated as an ‘in-network provider’ (Aetna, Medical Mutual and Blue Cross/Blue Shield). My business manager will submit these charges to those plans, and I expect a portion of these fees will be paid at the UCR level (usual and customary reimbursement). Please review your plan for more detailed information about benefits, especially copays and deductibles.

|  |  |
| --- | --- |
| **90791:**Psychiatric diagnostic evaluation; Initial Assessment | $285 |
| **90837:** 60 minutes of psychotherapy | $200 |
| **90840:**Each additional 30 minutes of psychotherapy for crisis | $100 |
| **90846:** 50 minutes of family psychotherapy without the patient present | $200 |
| **90847:** 50 minutes of family psychotherapy with the patient present | $200 |
| **Missed or Cancelled Appointments** without 24 hour notice  **Other professional services**: clinical summaries, responding to legal demands (e.g., depositions and trial testimony), report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. | Full fee  $200 hour |

My signature below indicates my understanding, agreement with, and acceptance of the GFE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Estimate of Services by Provider**

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| --- |
| **Jes James Sellers, PhD**  Licensed Psychologist Ohio #3529  2460 Fairmount Blvd., Suite 301  Cleveland Heights, OH 44106  **216.800.5370**  [**drjessellers@gmail.com**](mailto:drjessellers@gmail.com)  NPI 1982154209 EIN 814874882 |

**Details of Services and Items**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Service/Item | Address where service/item will be provided | Diagnosis Code | Service Code | Quantity | Expected Cost |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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| --- |
| **Total Expected Charges** The ultimate total fee for treatment services will be the number of sessions multiplied by the ongoing session fee. |
| **Additional Health Care Provider/Facility Notes** Due to the nature of mental health treatment, the number of total sessions in the treatment is unknown at the outset and is based on your needs, preferences, and the progress made in the treatment. |

**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.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

The good faith estimate is not a contract and *does not require* you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

**If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.** You may contact the health care provider or facility listed to let them know the billed charges are substantially in excess of the expected charges than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059. **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- 800-985-3059.

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