



# Embark Counseling Services, LLC

Empowering Children and Families for Hope and Healing

913-257-3161 – direct

888-965-8977 - fax

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## **Good Faith Estimate for in-network services**

Effective January 1, 2022, a ruling went into effect called the “No Surprises Act” which requires practitioners to provide a “Good Faith Estimate” about out-of-network care. The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your health care needs for an item or service, a diagnosis, and a reason for therapy. 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. In that case, you would be provided a new Good Faith Estimate. If this does happen, federal law allows you to dispute (appeal) the bill if you and your therapist have not previously talked about the change and you have not been given an updated Good Faith Estimate.

Under *Section 2799B-6 of the Public Health Service Act (PHSA)*, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage, or a Federal Health Care Program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request, or at the time of scheduling health care items and services to receive a “Good Faith Estimate” of expected charges. Note: The PHSA and Good Faith Estimate does not currently apply to any clients who are using insurance benefits, including “out of network benefits” (i.e., submitting superbills to insurance for reimbursement).

**Timeline requirements:** Practitioners are required to provide a Good Faith Estimate of expected charges for a scheduled or requested service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service. That estimate must be provided within specified timeframes:

- If the service is scheduled at least three business days before the appointment date, no later than one business day after scheduling
- If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling
- If the uninsured or self-pay client requests a Good Faith Estimate (without scheduling the service), no later than three business days after the date of the request

A new Good Faith Estimate must be provided within the specified timeframes if the client rescheduled the requested item or service.

### *Common Services at ECS*

- 90791 Initial Therapy Intake (only billed one time per 6 months per issue) **\$185.00**
- 90832 Psychotherapy, up to 37 minutes (with or without patient) **\$80.00**
- 90834 Psychotherapy, 38-52 minutes (with or without patient) **\$130.00**
- 90837 Psychotherapy, 53+ minutes (with or without patient) **\$155.00**
- 90846 Psychotherapy without patient present (Parent Session) – monthly in addition to individual psychotherapy session **\$165.00**
- 90847 Family Therapy (60 minute) **\$180.00**, or Couples and Relationship Therapy (60 minute) **\$195.00**
- 90847 Family Therapy (90 minute) **\$230.00**, or Couples and Relationship Therapy (90 minute) **\$255.00**
- 90785 (Interactive Complexity Code for Play Therapy, Telehealth and EMDR). In addition to primary code above. **\$20.00**
- 90853 Group Therapy **\$45.00**

5001 College Blvd, Suite 105, Leawood, KS 66211

225 SW Noel St, Lee's Summit, MO 64063

5020 Bob Billings Parkway, Suite C1 Lawrence, KS 66049

8350 N St Clair Ave, Kansas City, MO 64151

3105 Frederick Ave, Suite C, St Joseph, MO 64506

Services NOT billable to your health insurance, or covered by insurance:

- Insufficient Funds, Credit Card Denials and non-payment of services: **\$35.00**
- Interest (for outstanding balances and payment plans): **2% of the monthly balance.**
- Contact: Telephone assessment and clinical management, responding to emails, extended communication (in excess of 10 minutes) **Prorated based on \$155.00 per hour.**
- No show or late cancellation: Your therapist requires a 24-hour cancellation notice. If this is not provided, you are responsible for the fee of the scheduled appointment that is missed. **See above fees.**
- Production of records: Digital or printed, paid in advance of receiving records. Please allow 14 days. **\$30.00.**
- Legal Fees: All services related to court involvement, including court testimony, time spent reviewing records, preparing documents, travel time, communication with attorneys, and Guardian Ad Litem. **\$300/hr billed in 10-minute increments. We require a 3-hour minimum billed and paid in advance.**

### *Common Diagnoses at ECS*

Although it is difficult for us to provide an appropriate and confirmed diagnosis until a formal assessment is completed, we will provide one of the following diagnoses, however, the list is not exhaustive:

- Parent-Child Relational Problem (Z62.820)
- Child Affected by Parental Relational Distress (Z62.898)
- Relationship Distress with Spouse or Intimate Partner (Z63.0)
- Stress not elsewhere specified (Z73.3)
- Z65.9 Unspecified Problems related to Unspecified Psychosocial Circumstances

The above diagnoses are not intended to be a formal psychological diagnosis, and these diagnoses are only used to satisfy the requirements of this form. A formal diagnosis occurs after the assessment phase of your treatment has been completed, which usually takes place approximately 4-6 sessions after beginning psychotherapy. We must provide a diagnosis to bill your health plan.

ECS recognizes that every client’s therapy journey is unique. Typically, our therapists will follow weekly session protocol, until an alternative frequency is needed. This is generally determined by the intensity of the presenting concerns, best practice with the delivery of treatment and ethical considerations. How long you need to engage in therapy, and how often you need to attend therapy will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess for appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge.

### *Where Therapy Services will be Delivered*

ECS has four locations, and all locations follow the same fee structure, including our telehealth services. Our EIN is 46-4668351 for all locations. Below are our addresses, and your services will primarily be delivered at the location you identified during the Initial Phone Consultation, and where your counselor works. Telehealth may also be available and is inclusive within these locations.

Leawood Office	Lee’s Summit Office
5001 College Blvd, Suite 105	225 SW Noel Street
Leawood, KS 66211	Lee’s Summit, MO 64063
Northland (Kansas City, MO)	St. Joseph, MO
8350 N. St. Clair Avenue, Suite 275	3105 Frederick Avenue, Suite C
Kansas City, MO 64151	St. Joseph, MO 64506

Lawrence Office
5020 Bob Billings Parkway, Suite C1
Lawrence, KS 66049

### Client Information

First & Last Name	Date of Birth (MM/DD/YYYY)
Street Address	City, State, Zip
Best Phone Number (xxx)xxx-xxxx	Email address

**Your provider and Supervisor (if applicable):** \_\_\_\_\_, has been identified as being in network with my health plan. Please refer to your intake questionnaire for your clinician’s information and NPI.

### Financial Responsibility Summary

For a Good Faith Estimate, we recognize that the amount you may owe on a weekly basis is outlined above. Your actual financial responsibility is determined based on how your insurance benefits are processed by your health insurance company. If your claims are processed in network, we have agreed to accept the allowable amount as the service fee for each service billed. However, if your insurance company denies the claim, your financial responsibility is for the full fee of the service provided, including any late fees or interest fees.

**By signing, I acknowledge that I have received expected verification of my mental health benefits according to my health plan. I understand that the insurance company may process my claims differently when claims are presented for payment. If claims are processed differently than expected, I understand that I am responsible for the amounts described in the explanation of benefits.**

**Client or Guardian Signature:** \_\_\_\_\_

**Date of this Good Faith Estimate:** \_\_\_\_\_

**Good Faith Estimate Disclaimer:** The Good Faith Estimate shows the costs of items and services that are reasonably expected for your mental 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. 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 higher 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. Call your health plan; you may have better information about how much you will be asked to pay. You can also ask about what’s covered under your plan and your provider options. You may also start a dispute resolution process with the US Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute within 120 calendar days (about 4 months) of the date on the original bill. There is a **\$25.00 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, you will have to pay the higher amount. If you have questions about your rights, or to get a form to start the process, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 800-985-3059.

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