Dr. Michelle Kukla's Good Faith Estimate for Psychological Services

[Dr. Michelle Kukla, 579 N. First Bank Dr., Suite 150, Palatine, IL 60067] [Phone: 847.701.4452]

Date of Good Faith Estimate: ___/____/___ This estimate is for psychotherapy services through ____________________

(Date)

Starting January 1, 2022, new legislation went into effect that requires health care providers and facilities to inform self-pay and uninsured individuals of their right to receive a "Good Faith Estimate" of expected charges. The purpose of the law, known as the "No Surprises Act", (NSA) is to protect self-pay/uninsured consumers from unanticipated and expensive bills for out-of-network services.

If you are uninsured or don't plan to use your insurance:

- You have the right to receive a Good Faith Estimate (GFE) explaining how much your treatment will cost.
- You have the right to receive the GFE at least one (1) business day before your first scheduled appointment.
- You have the right to dispute the bill if your costs are $400 or more over your GFE.
- Be sure to save a copy or picture of your GFE for future reference.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call Dr. Michelle Kukla to receive a Good Faith Estimate at (847) 701-4452.

Brief explanation of estimate for new patients:

The estimate below is the [range of costs]/cost that is likely for most new patients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs. I typically see therapy patients for __________ sessions for a total cost of $________________. But in [some/many] cases a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

Brief explanation for continuing patients: The estimate below is the [range of costs]/cost that I think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact Dr. Michelle Kukla about the GFA at [847-701-4452].

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled for the next____________ months starting on ________________________. The estimated costs are valid for ___________ months from the date of this Good Faith Estimate, unless [I/we] send you an updated estimate.

Service	**Diagnosis Code** (once determined)	**Service code**	**Quantity** (# of sessions or units. Give number or range)	**Cost per unit**	**Expected cost**
Initial evaluation	[use ICD codes]	90791		$	$
Psychotherapy		90837 and/or 90834		$	$

Total estimated cost: $___________________________________ **Psychologist providing services:** _Dr. Michelle Kukla

NPI number: 1225388697 TIN: 45-5340926

Patient information:

Patient name ____ DOB _____________________

Client signature: ____ ___________________

(Adult/Parent/Guardian) (Date)

Witness/Psychologist: ____ ___________________

(Date)

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to me when [we/I] did the estimate.

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 Dr. Michelle Kukla at the contact listed above 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.

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 CMS at 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 CMS at 1-800-985-3059.

This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than $400 than the estimate provided above.