Individual, Couple & Family Psychotherapy
Serving Cologne, Eden Prairie and Glencoe
925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
www.thejonascenter.com

GOOD FAITH ESTIMATE CLIENT RIGHTS

(Required for all uninsured or self-pay clients, *Public Health Service Act Section 2799B-6 Section 2799B-6*)

If you don't have insurance or you are choosing not to use your insurance, you have the right to receive a "Good Faith Estimate" explaining how much your mental health care will cost. Under the law, we need to provide you with an estimate of the charges for the services we provide.

- You have the right to receive a Good Faith Estimate for the total expected cost of the mental health services provided by The Jonas Center.

- You have the right to have your therapist give you a Good Faith Estimate in writing at least 1 business day before your scheduled appointment. You can also ask your therapist or the Director for a Good Faith Estimate before you schedule a service or at the time of your first appointment.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. The dispute resolution process is the following:
  1. Place your concerns in writing through email or on paper and address it to James Jonas, Director, email jjonas@thejonascenter.com or mail to 925 12th St E, Glencoe, MN 55336.
  2. Mr. Jonas will review your concerns with your therapist and determine possible options in addressing your concerns and then contact you no later than 30 days from the date of receiving your dispute.
  3. A written response will be provided to you once there is resolution.
  4. You may also file a dispute with the U.S. Department of Health and Human Services (HHS) by contacting them at www.cms.gov/nosurprises

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call James Jonas, Director at 952-361-9700.

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CLIENT NAME:_____DOB:_____

ADDRESS:_____

PHONE:_____EMAIL:_____

Preferred Method of Contact:_____Mail_____Email

PRIMARY SERVICES REQUESTED:

Diagnostic Assessment (CPT Code 90791): $225.00 Date Scheduled:_____

Individual/Family Therapy, Other
(CPT 90837, 90847, Other:_____): $175.00 Date Scheduled:_____

Estimated number of appointments:

_____@ $175.00 = $_____

ESTIMATED TOTAL COST $_____
(See Sliding Fee Policy and Procedures to adjust fees if client is eligible for a reduced fee. Clients having insurance and choosing not to use it will be charged the full fee.)

PRIMARY DIAGNOSIS:_____

PROVIDER NAME:_____

DATE OF GOOD FAITH ESTIMATE:_____

- It is anticipated that no other services from this agency will need to be provided. Additional services may be recommended from another agency.
- The information provided in this Good Faith Estimate is only an estimate of services created on this date and actual charges may differ.
- The Good Faith Estimate is not a contract and does not require the uninsured or self-pay individual to obtain the services from the provider identified in this Good Faith Estimate.
- The client has the right to initiate the client-provider dispute resolution process if the actual billed charges are $400.00 or more of the expected charges included in this Good Faith Estimate.