INSTITUTE FOR CHILDREN'S AID
A Voice of HOPE for Children Worldwide

951-695-3336
info@4achild.org
www.instituteforchildrensaid.org
A Division of International Christian Adoptions

HEADQUARTERS:
41745 Rider Way #2
Temecula, CA 92590

BRANCH OFFICE:
333 University Ave., Ste. 200
Sacramento, CA 95825

BRANCH OFFICE:
6248 Birdcage Street
Citrus Heights, CA 95610

BRANCH OFFICE:
1800 Martin Luther King Parkway
Ste. 200, 201, Durham, NC

GOOD FAITH NOTICE

THE LAW

Due to the "No Surprises Act," it requires health care providers (including mental health providers), to inform their uninsured and private pay clients that they have a right to a "Good Faith Estimate" to help clients estimate their expected charges the may be billed for.

NOTICE TO CLIENTS

NO RATE PROGRAMS
ICA is reimbursed by government, foundation or private donations OR counseling costs were already covered in programs and your counseling sessions are a non-expense to you.

MODIFIED RATES
Some clients are experiencing extraordinary circumstances and there are legitimate reasons for reductions of fees. This is accomplished by request and an approved application process.

NORMAL RATES
Our normal rates are listed in the Informed Consent, and the Good Faith Estimate specifically.

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.
Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.
You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400.00 more than your Good Faith Estimate, you can dispute the bill. 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.

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GOOD FAITH ESTIMATE

CLIENT INFORMATION

Client Name		Client DOB	
Client Address			
Client Diagnosis		Date of Initial Assessment	
Service Requested		Date of GFE	

PROVIDER INFORMATION

Provider Name		Provider License	
Provider Address			
Provider Phone			
Provider Tax ID		Provider NPI	

WHAT IS THE GOOD FAITH ESTIMATE

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

DISCLAIMERS

Clients participate in counseling services in by one of the following means:

NO RATE PROGRAMS:
ICA is reimbursed by government, foundation or private donations OR counseling costs were already covered in programs and your counseling sessions are a non-expense to you.

MODIFIED RATES:
Some clients are experiencing extraordinary circumstances and there are legitimate reasons for reductions of fees. This is accomplished by request and an approved application process.

NORMAL RATES:
Our normal rates are explained below.
There may be additional items or services the provider (counselor/clinician) may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400.00 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

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GOOD FAITH ESTIMATE

The fee for a 50-minute psychotherapy visit (in person or via telehealth) is $50.00. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. (This includes individual sessions, family sessions, group therapy, psychoeducational sessions, behavioral sessions, etc. Additional services and fees beyond that will be discussed at the time of service, and a new GFE can be produced for the additional services beyond the regular services discussed.) Based on a fee of $50.00 per visit, the following are expected charges of psychotherapy services:

Number of Weeks	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per week
1 Week of Service	$50	$100
13 Weeks of Service (Approx. 3 Months)	$650	$1300
26 Weeks of Service (Approx. 6 months)	$1300	$2600
39 Weeks of Service (Approx. 9 months)	$1950	$3900
52 Weeks of Service (Approx. 12 Months)	$2600	$5200

ADDITIONAL INFORMATION

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

DATE

Date of this Good Faith Estimate: _____

SIGNATURES

By signing, this means that I agree that the above information is an accurate representation of what was discussed in the GOOD FAITH ESTIMATE.

Client Signature	Client Name	Date	Parent / Guardian Signature	Parent / Guardian Name	Date

ICA Provider Signature	ICA Provider Name / Title	Date	Supervisor Signature (If Applicable)	Supervisor Name / Title	Date