Link Relationship Counseling LLC

Gina R. Young, MA, BCPCC, LPC

GOOD FAITH ESTIMATE

Client Information

Name: _____ Date of Birth: _____

Provider Information

Provider name: Gina R. Young, LPC of Link Relationship Counseling, LLC

Provider phone number: 715-446-0007

Provider e-mail address: ginayoung@linkrelationshipcounseling.com

National Provider Identifier (NPI): 1962821454

Licensed Professional Counselor (LPC) Number: 5183-125

Employer Identification Number (EIN): Available upon request

Details of Services Provided

Service:___Psychotherapy and/or Counseling with Individual Client_____

Address where service is provided: Link Relationship Counseling, LLC 4714B Commerce Valley Rd, Eau Claire, WI 54701

Diagnosis code [ICD-10]: _____

Service code(s): ___90834_____

Cost per Session:___$110 per 45-53 minute session_____

If you were to attend weekly sessions for all 52 weeks during the calendar year the cost would be $5720.

Your provider expects you will need _____ session(s) for a total cost of $_____ during this calendar year.

_____	_____	_____
Client's Signature	Print Name	Date
_____	_____	_____
Provider's Signature	Print Name	Date

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. 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.

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 HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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.