



Link Relationship Counseling LLC

Gina R. Young, MA, BCPCC, LPC

GOOD FAITH ESTIMATE

Client Information

Name: _____ Birthdate: _____
Name: _____ Birthdate: _____

Provider Information

Provider name: Gina R. Young, LPC at 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: Couple Relationship Counseling

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

Diagnosis code [ICD-10]: Z63.0 Problems in relationship with spouse or partner

Service code(s): 90847 + 99354 + 99355 + 99355 + 99355 + 99355 (For five hour full-day service)

Quantity: 1-6 full-day sessions or 1 full-day session with 1-20 shorter follow-up sessions

Expected cost: Each full-day session is considered five hours of direct service and costs \$600. Depending on number of full-day sessions, the cost could range from \$600 (1 day/5 hours) to \$3600 (6 days/30 hours). For shorter sessions, each therapy hour is billed at \$120 for 45-55 minutes. If you choose to attend more than 30 hours of therapy during a calendar year your cost may be higher than \$3600 for the year.

Your provider expects you will need _____ therapy hours for a total cost of \$ _____ during this calendar year.

Client's Signature

Client's Signature

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.