Good Faith Estimate

This estimate is for treatment services reasonably expected to be furnished over the next 12 months, unless you receive an updated estimate.

Service Provider: Kelly L. LeMaire, Ph.D.; Inspired Growth Therapy PLLC

NPI1 number: 1619609096 EIN: 93-3592790

NPI2 number: 1679340483

The estimate below is the range of expected costs/typical charges for your treatment services if you are paying fully out of pocket. However, more or fewer sessions may be needed depending on your treatment progress. Additionally, if you have insurance your out of pocket expenses may be *significantly* less.

Date of service	**Service code**	**Description**	**Estimated amount**
To be determined	90791	Initial Evaluation	$240
" "	90837	Individual Psychotherapy 53+ minutes	$210
" "	90834	Individual Psychotherapy 38-52 minutes	$180
" "	90847	Family Psychotherapy 50 minutes with client present/Couple's Therapy	$240

Number of Weeks	Total estimated charges for weekly sessions
13 Weeks of Services (Approx. 3 Months)	$2760
26 Weeks of Services (Approx. 6 months)	$5490
39 Weeks of Services (Approx. 9 months)	$8220
52 Weeks of Services (Approx. 12 Months)	$10,950

The fees above are only an estimate for services reasonably expected to be furnished at the time the estimate is issued. Actual services or charges may differ from this estimate based on frequency or other variables. The estimate does not include late cancelation/no show fees or other charges which may be incurred on a case-by-case basis. My expectation is open communication between us relating to fees for any additional treatment services provided.

If you have insurance, your estimated costs will likely be significantly lower.

No show/Late cancellation fee

Cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. This means that other paid work cannot be done during this time. Insurance companies do not reimburse for missed sessions. The first missed session will be charged for $60 and every subsequent no show or late cancel charge will be $180

Number of Weeks	Total estimated charges no show or late (less than 24 hours) cancellation
First time	$60
Every subsequent miss	$180
4 missed sessions	$600

Other fees

There are times that therapists are needed to provide other services such as completing paperwork other than regular documentation, preparing reports, or coordinating care with other professionals. You may be charged a fee for these services provided at $80 dollars an hour. Whether this charge will be incurred will be assessed on a case-by-case basis depending on the nature of the work as well as how long it takes to complete. You can discuss this with your therapist before the task is completed.

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 at the time of this 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. However, I will work with you as circumstances warrant in order to avoid any surprises in the amount you are charged for any particular treatment services.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

Please contact me if the billed charges are higher than the Good Faith Estimate. You can ask me 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, and/or 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(s) provided above.