

**George Hage LCMHCS/Counseling and Spirituality]**  
**Good Faith Estimate for Health Care Items and Services**

<b>Patient</b>		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
<b>Patient Mailing Address, Phone Number, and Email Address</b>		
Street or PO Box	Apartment	
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email		
<b>Patient Diagnosis</b>		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

If scheduled, list the date(s) the Primary Service or Item will be provided:	
<input type="checkbox"/> Check this box if this service or item is not yet scheduled	
Date of Good Faith Estimate: _____/_____/_____	
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
<b>Total Estimated Cost: \$</b>	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

OMB Control Number [\_\_\_\_-\_\_\_\_]  
 ExpirationDate [\_\_/\_\_/\_\_\_\_]

**[Provider/Facility 1] Estimate**

Provider/Facility Name		Provider/Facility Type	
Street Address			
City	State	ZIP Code	
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

**Details of Services and Items for [Provider/Facility 1]**

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

<b>Total Expected Charges from [Provider/Facility 1] \$</b>
Additional Health Care Provider/Facility Notes



## Counseling and Spirituality

George Campbell Hage, Ed. D., Ph. D., LCMHCS, 3153 Reynolda Road, Winston-Salem, NC 27106,

Solo Practice 000-00-0507

Tel: 336-749-4163, email: [george@counselingandspirituality.org.in](mailto:george@counselingandspirituality.org.in)

Date: \_\_\_\_\_

Please know that a client who chooses me as their therapist understands that I do not take insurance in this solo practice. Also, I provide an affordable service for client's who cannot afford today's high counseling costs. The rate that a client begins seeing me is set at \$50-\$60 for Individual or Couples therapy. However, during therapy, this rate may be waived if the client comes into hard times financially. Clients who find themselves well off financially may offer to give more money for services rendered if they so desire and are feeling my counseling services are benefiting them. Clients are not expected to sign any contract or pledge that they will give more. A client's giving more when they can, helps me to afford to see other clients who cannot afford therapy or enter hard times financially. If a client enters therapy and is hindered by low income, such as being on disability, the \$50-60 fee can be waived from the onset. The said fee is for modes of counseling including individual, family, and couples except for group counseling with the fee being \$20- \$30 per session. At the same time, I cannot gage the total costs per annum for a client due to what is said in this statement, and my clients most likely do not engage in counseling consistently at such intervals as one session per week or one session per two weeks, etc. However, I can provide an invoice of sessions provide at the client's request ipso facto as I keep a list of all payments for tax purposes. Please note that this statement relates to the Good Faith Estimate for Health Care Items and Service.

Please sign and date below:

\_\_\_\_\_  
George Campbell Hage, Ed. D., Ph.D., LCMHCS (S2165)  
Doctorates in education and theology

\_\_\_\_\_  
Client or Clients

## **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/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059.

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059.

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.