Good Faith Estimate

Why are you receiving this form?

Beginning January 1, 2022, new federal protections will shield millions of consumers from surprise medical bills—unexpected bills from an out-of-network provider, out-of network facility or out-of-network air ambulance provider. The protections, implemented under the No Surprises Act, ban surprise billing in private insurance for most emergency care and many instances of non-emergency care. They also require that uninsured and self-pay patients receive key information, including overviews of anticipated costs and details about their rights. (Excerpt from CMS.gov Press Release, January 3, 2022.)

You are receiving this form because you are an uninsured or self-paying patient. The No Surprises Act requires us to provide you with this information 72 hours before receiving the relevant service.

By completing this form, you (the consumer) are helping me (the therapist) to give you the best possible Good Faith Estimate of costs that you may be billed for.

By signing this form, you acknowledge that you are giving up certain federal consumer protections, and that you may owe the full costs billed for services received. You don't have to sign this form, but if you don't sign, this provider might not treat you.

Patient Information

Please enter your demographic information below.

First and Last name:
Date of birth:
Address:
City:
State:
Zip Code:
Email:
Phone Number:
Preferred Form of Contact:

Provider Information
Provider name: A Johnston Therapy, PLLC
Provider/facility type: Alana Johnston, LCSW; Craig Burns, LMSW
Address: 2300 Library Circle, Grand Forks, ND 58201; 600 Demers Ave Suite 303, Grand Forks, ND 58201
Contact person: Christina Loh, Office Manager
Phone: 701-757-0292

Email: information@ajohnstontherapy.com
National Provider Identifier (NPI): 1740714161
Taxpayer Identification Number (TIN): 87-2495893

Details of Services and Items for A Johnston Therapy, PLLC

The type and frequency of services may vary greatly from patient to patient. Therefore, A Johnston Therapy, PLLC cannot ethically predict the exact dollar amount that you will be charged. Below is a detailed list of the types of services, together with the fee structure and the Current Procedural Terminology (CPT) codes.

Please fill out the section below to obtain a Good Faith Estimate of your expected costs. For example, if you intend to see your therapist once a week (52 times a year) for 38-52 minutes, then enter 52 x $190 = $9,880 in the section that says “Please add up your entries above to obtain your Good Faith Estimate”

The Good Faith Estimate will be valid for 12 months.

* Please fill out your estimated costs below, based on how many times you intend on seeking services in a 12-month period (52 weeks).

1. Initial Diagnostic Evaluation (CPT Code 90791): Only done once a year. Please enter $285.
2. Psychotherapy (53 minutes or more, CPT 90837): Multiply number of sessions by $240.
3. Psychotherapy (38 to 52 minutes, CPT 90834): Multiply number of sessions by $190.
4. Psychotherapy (16 to 37 minutes, CPT 90832): Multiply number of sessions by$125.
5. Family/Conjoint Psychotherapy with Patient Present (50 minutes, CPT 90847): Multiply number of sessions by $195.
6. Psychotherapy for Crisis (60 minutes, CPT 90839): Multiply number of sessions by $235.*

Please add up your entries above to obtain your Good Faith Estimate: Total Here

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, such as Interactive Complexity (CPT Code 90785, $30 per occurrence) or No Show/Late Cancellation ($100 per occurrence). (Details are in the "PSYCHOTHERAPY AGREEMENT, POLICIES, AND CONSENT FORM" that you were provided with earlier.) In such situations, 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.

By signing this form, you agree to be treated by A Johnston Therapy, PLLC, and you acknowledge that:

- you are giving up some consumer billing protections under federal law - you will be billed for the full cost of services provided
- you have obtained a Good Faith Estimate of the estimated cost of services, electronically, via completing this form
- you can end this agreement by notifying A Johnston Therapy, PLLC in writing before getting services.

You don't have to sign this form. But if you don't sign, this provider might not treat you. You can choose to get care from a provider in your health plan's network, or from another provider of your choosing.

I have read and agreed to all the above and I consent to sharing information provided here.

Signature
Date