

## MISSION

The **BabbCenter** is a ministry of First Baptist Church of Hendersonville, Tennessee. Our ministry is one of healing and hope based on the principles and example of Jesus Christ. Church members and people from the community are equally welcome. Counseling practices are based on Christian principles, sound academic training, and biblical guidelines.

## GOOD FAITH ESTIMATE

You are entitled to receive a good faith estimate of what the charges could be for counseling services provided to you. While it is not possible for a counselor to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of counseling sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

## WHY YOU ARE RECEIVING THIS GOOD FAITH ESTIMATE

On January 1, 2022 a portion of the “No Surprises Act” was implemented. This federal law was passed to help to protect people from surprise medical bills when receiving “out of network” or “private pay” care. You are receiving this notice because this provider or facility isn’t in your health plan’s network. This means the provider or facility doesn’t have an agreement with your plan to cover the cost of counseling services. Getting care from this provider or facility could cost you more.

You aren’t required to sign this form and shouldn’t sign it if you didn’t have a choice of health care provider. You can choose to get care from a provider or facility in your health plan’s network, which may cost you less. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility.

A summary of estimated costs are provided below so that you may compare the costs of receiving out of network/private pay care and the costs of receiving in-network services.

## COST PER SESSION-

The per session fee for your provider is \$50.00

Your counselor is a practicum student or intern who is under supervision by a **BabbCenter** counselor and a supervisor at their university .

## ESTIMATED CHARGES SUMMARY

| Number of Weeks                    | Bi-Weekly | Weekly |
|------------------------------------|-----------|--------|
| 4 Weeks (approximately 1 month)    | \$100     | \$200  |
| 26 Weeks (approximately 6 months)  | \$650     | \$1300 |
| 52 Weeks (approximately 12 months) | \$1300    | \$2600 |

If you cancel your appointment less than 24 hours prior to your session or miss the appointment, you will be charged \$50.

## ADDITIONAL SERVICES

There may be services recommended as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services rendered to you that are not identified here.

## ADDITIONAL FEES

You may request services in addition to a scheduled appointment. These services are not included in the good faith estimate. Common requests and associated fees are listed below. Please note this is not an exhaustive list.

| Service Requested                | Estimated Fee                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Phone consultation               | Full session fee if longer than 15 minutes                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Formal letter from the counselor | Full session fee unless additional time is required                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Copy of counseling records       | \$20 for first 25 pages, \$0.10 for each additional page                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Deposition/Court testimony       | <p><b>NOTE: prepayment required for court appearance/testimony</b></p> <p>Summary of Court fees</p> <ul style="list-style-type: none"> <li>• Court preparation time (\$50 per hour of preparation)</li> <li>• Travel, wait &amp; testimony delivery time (\$100 per hour)</li> <li>• Mileage &amp; parking (Federal mileage rate and parking fees)</li> <li>• Cancellation of appearance within 48 hours of scheduled proceeding (\$50 per session lost during time allotted)</li> </ul> |

## INSURANCE

Most counselors at the **BabbCenter** are not on insurance panels. If you wish to file with your insurance company, you will be furnished a receipt for payment of services rendered upon request.

If your counselor is on insurance panels, we will begin filing upon notification of intent to use insurance and verification of coverage. However, we are unable to file any sessions prior to notification of intent to use insurance.

## DISPUTE RESOLUTION

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [www.babbcenter.org](http://www.babbcenter.org) or ask to speak with the Director of the **BabbCenter**. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

## SUMMARY

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist.

You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

***Please sign the agreement below indicating your commitment to be responsible for the fee for your 50-minute session.***

Printed name of client

Client signature  
(Parent/legal guardian if minor)

Date