GUIDING PATHS
COUNSELING

Katie Frazee, MS, LCPC, NCC, MAC
93 S McCain Drive, Suite 1
Frederick, MD 21703
240-415-8777 (Phone)
240-444-8075 (Fax)
kfrazee@guidingpaths.com

"Good Faith Estimate" Disclosure

Under section 2799B-6 of the Public Health Service Act, healthcare providers and healthcare facilities are required to inform individuals who are not enrolled in a plan or coverage, or a Federal health care program, or not seeking to file a claim with their plan or coverage, both orally and in writing, of their ability, upon request, or at the time of scheduling, healthcare items and services, to receive a "Good Faith Estimate" of expected charges. The "Good Faith Estimate" does not include any unknown or unexpected costs that may arise during treatment. There could be additional charges if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

My Rights to Receive a "Good Faith Estimate"

1) You have the right to receive a "Good Faith Estimate" for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees
2) You have the right to receive the "Good Faith Estimate" in writing at least one business day before your medical service or item. You can ask your healthcare provider, and any other provider you choose, for a "Good Faith Estimate" before you schedule an item or service
3) You have the right to dispute any bill that exceeds $400 from the "Good Faith Estimate" that was provided to you by your healthcare provider. You may contact the healthcare provider or facility and request them to update the bill to match the "Good Faith Estimate," ask to negotiate the bill, or inquire about financial assistance
4) 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 of the date on the original bill
5) Make sure you save a copy or take a picture of your "Good Faith Estimate" for your records

Questions About Your Rights and Protections?

If you believe you have been wrongly billed, you may contact:

Maryland Insurance Administration
https://insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx
1-410-468-2000 or 1-800-492-6116 (TTY: 1-800-735-2258)

To receive more information about your rights under Maryland law, please visit:

Maryland Insurance Administration
https://insurance.maryland.gov/Consumer/Pages/HealthCoverage.aspx

To receive more information about your rights under federal law, please visit:

Centers for Medicare and Medicaid Services (CMS)
https://www.cms.gov/nosurprises/consumers
1-800-985-3059 (File a complaint)

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"Good Faith Estimate" Disclosure

My signature below indicates that I, ____, have received a copy of the **"Good Faith Estimate" Disclosure** and that I understand the contents of this form. My signature also indicates that my clinician has explained and/or summarized the information in this form and has allowed an opportunity for me to ask questions regarding this information.

____ _______________________________

Client Signature Date

____ _______________________________

Guardian Signature (if applicable) Date

____ _______________________________

Clinician Signature Date