GOOD FAITH ESTIMATE

for Clinical & Forensic Mental Health Services with Dr. Harry L. Morgan

In 2021, Congress enacted the Consolidation Appropriations Act (CAA), the Affordable Care Act (ACA), and the Public Health Service (PHS) Act, all of which are effective January 1, 2022. These Acts impose important new transparency requirements on hospitals and pharmacies, and on medical and mental health providers. The following statements are in compliance with Section 2799B–6, as added by Section 112 of Division BB of the CAA. The purpose of the CAA is to protect clients from unexpected bills for healthcare services.

1. Patient's Name: _____

2. Patient's DOB: _____

3. Patient's Address: _____

4. Patient's Insurance: _____

5. Policy Number: _____

6. *Check all boxes that apply to you.*

☐ I do not have insurance.

☐ I do not intend to submit a claim to my insurance company for coverage of services received by Dr. Harry Morgan.

☐ I intend to submit a claim to my insurance company for coverage of services received by Dr. Harry Morgan.

☐ I received this Good Faith Estimate at the time of my appointment, before services were rendered.

☐ I understand that this estimate is not binding and that I may challenge a bill if the charges substantially exceed the estimated amount.

7. Patient Diagnosis: _____

8. Anticipated Length of Treatment: _____

9. Fee Schedule:

☐ Initial Evaluation $225 (90791)

☐ Individual Psychotherapy ☐30" $125 (90832) ☐45" $225 (90834)

☐ Individual Psychotherapy 45" $225 (90834-95) *(telehealth)*

☐Family Psychotherapeutic Session With Patient – $250 (90847)

☐Individual Psychotherapeutic Session Without Patient – $225 (90846)

☐Group Therapy Session – $40 (90853)

☐Crisis Psychotherapeutic Session – 60" $375 (90839)

☐For each additional 30" for Session $175 (90840)

☐Forensic Mental Health Evaluation – $5,500 *(not including additional testing, time beyond 15 hours, and court appearances)*

☐Psychosexual Risk Assessment – $4,500 *(not including additional testing, time beyond 15 hours, and court appearances)*

☐Sex Offender Risk Assessment – $2,500 (*not including additional testing, time beyond 15 hours, and court appearances)*

☐Forensic Assessment for PTSD – $2,500

☐Forensic Assessment for Autism – $3,000

☐Forensic Assessment for Competency – $5,500

☐Additional time preparing forensic reports – $175 per hour (a time log will be submitted to me of additional hours required to complete my report).

☐Court Appearances – $400 per hour (including travel time).

☐Other: _____

10. Available Discounts: A 10% discount is available to all active-duty military and military veterans with an honorable discharge, and first responders (i.e., active, or retired police, firemen, and EMTs) for psychotherapeutic treatment. These discounts are not available for probation, mental health assessments, and court related forensic evaluations.

☐ I am active-duty military.

☐ I am a veteran with an honorable discharge.

☐ I am an active or retired police officer, firemen, and/or EMT.

12. Fees:

Service Code	Description	Frequency	Cost	Discount *(if applicable)*	Totals

See Schedule of Fees for additional costs of services.

- For questions about the Patient Healthcare Agreement and this Good Faith Estimate call our office at 941-729-6600 to explain these documents and to answer any questions you may have.
- If you have questions about your patient rights, contact: https://www.tcrh.org/sites/twincounty/assets/uploads/About%20Us/patient_rights.pdf

13. By signing, I give up my federal consumer protections and agreed to pay more for out of network care.

With my signature, I am saying that I agree to receive services from:

☐Dr. Harry L. Morgan, LMHC License # MH10635

☐Clinical & Forensic Mental Health Services 7458 North Tamiami Trail, Sarasota, FL 34243

14. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured, I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services or have to pay out of network cost sharing under my health plan.
- **I was given this written notice on *(date)*:** _____ explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may also if I agreed to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

Important: You **don't** have to sign this form. But if you don't sign, this provider facility might not treat you can choose to get care from a provider facility in your health plans network.

_____		_____
Patient's Signature	OR	Guardian/Authorized Representatives Signature
_____		_____
Print Name of Patient		Print Name of Guardian/Authorized Representative
_____		_____
Date & Time of Signature		Date & Time of Signature

Bring this form with you at the time of your initial session.
Dr. Morgan cannot provide treatment without it.
You will be provided with a copy of this form.