



Self-pay Financial Waiver & Good Faith Estimate

Our self-pay discount is designed to assist clients who are not using insurance for their behavioral health services. In these situations we want you to know what to expect so that you can make an informed decision. In order to accomplish this, please review the information below regarding Wellpoint Care Network's self-pay agreement and your rights regarding a Good Faith Estimate.

Self-Pay Agreement:

- ❖ You do not have any insurance coverage or have a noncontracted insurance company but do not want your insurance billed and instead want to pay out of pocket.
- ❖ If you have insurance or other types of coverage, services received for your visits that are included in the "self-pay" discount will not likely be reimbursed by your carrier or applied to your deductible and/or out of pocket costs. You may want to discuss this with your insurance carrier before agreeing to the self-pay discount.
- ❖ You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services.
- ❖ Until I advise Wellpoint in writing, I will elect to self-pay for all services I receive from The Clinic at Wellpoint.
- ❖ The Clinic at Wellpoint offers a **20% self-pay discount** on the original charge.
- ❖ I understand Wellpoint Care Network's service fees and my responsibility based on the Good Faith Estimate information below

Good Faith Estimate Notice:

- ❖ 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, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.
- ❖ The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.
- ❖ If you are billed for more than this Good Faith Estimate, you may 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.
- ❖ If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.
- ❖ For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers , email FederalPPDRQuestions@cms.hhs.gov , or call 1-800-985-3059.



Good Faith Estimate Details

Facility Information

- ❖ Address-Wellpoint Care Network 8901 W. Capitol Dr. Milwaukee, WI 5322
- ❖ NPI-1639343320
- ❖ TIN-391338354

Contact

- ❖ Clinical Services Manager- Aubrey Winkie
- ❖ Phone: 414-465-5762
- ❖ Email: awinkie@wellpointcare.org

Services Provided:

- ❖ Intake: Psychiatric Diagnostic Evaluation- see below
- ❖ Ongoing: determined by treatment plan of diagnostic evaluation, see possible rates below.

Diagnosis

- ❖ Initial Visit: Unknown
- ❖ Ongoing Therapy: determine by diagnostic evaluation

<u>Original Fee</u>	<u>20% Self-Pay Discount</u>	<u>Self-Pay</u>	<u>Service Description</u>
\$225.00	\$45.00	\$180.00	Psychiatric diagnostic evaluation
\$100.00	\$20.00	\$80.00	Psychotherapy, 30 minutes with patient
\$150.00	\$30.00	\$120.00	Psychotherapy, 45 minutes with patient and/or family member
\$200.00	\$40.00	\$160.00	Psychotherapy, 60 minutes with patient and/or family member
\$205.00	\$41.00	\$164.00	Psychotherapy for crisis; first 60 minutes
\$100.00	\$20.00	\$80.00	Psychotherapy for crisis; each additional 30 minutes
\$175.00	\$35.00	\$140.00	Family psychotherapy (without the patient present), 50 minutes
\$175.00	\$35.00	\$140.00	Family psychotherapy (with patient present), 50 minutes
\$75.00	\$15.00	\$60.00	Group psychotherapy (other than of a multiple-family group)
\$40.00	\$8.00	\$32.00	Interactive complexity
\$350.00	\$70.00	\$280.00	Medication Management Psychiatric Evaluation, 60-75min
\$200.00	\$20.00	\$180.00	Medication Management Follow-Up, 20-30 Minutes

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Client Name (First, Last)

Date of Birth

Client Signature

Date

Parent/Legal Guardian Signature

Date