GOOD FAITH ESTIMATE & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITIES

Under the law, health care providers need to give patients who do not have insurance, or who are not using insurance, or are out of network, an estimate of the bill for medical items and services.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. Please be advised, your fee may change depending on the number of sessions you attend. Services outside of standard therapy may have an associated extra cost. Please refer to our Practice Policies for a complete list of fees and services.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or items. You can also ask your healthcare provider and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775.

You may qualify for a fee discount based on family income and family size which can potentially affect your final cost.

Household Income: _____ Household Size: _____

The Bert Nash CMHC Sliding Fee Scale effective September 15, 2023 is shown below. Per the information provided by you, your discounted rate is: (staff to circle rate)

DISCOUNT %		90%		80%		60%		40%		20%		0%
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	OVER
HOUSEHOLD SIZE	1	$0	$14,580	$14,581	$21,870	$21,871	$29,160	$29,161	$36,450	$36,451	$43,740	$43,741
	2	$0	$19,720	$19,721	$29,580	$29,581	$39,440	$39,441	$49,300	$49,301	$59,160	$59,161
	3	$0	$24,860	$24,861	$37,290	$37,291	$49,720	$49,721	$62,150	$62,151	$74,580	$74,581
	4	$0	$30,000	$30,001	$45,000	$45,001	$60,000	$60,001	$75,000	$75,001	$90,000	$90,001
	5	$0	$35,140	$35,141	$52,710	$52,711	$70,280	$70,281	$87,850	$87,851	$105,420	$105,421
	6	$0	$40,280	$40,281	$60,420	$60,421	$80,560	$80,561	$100,700	$100,701	$120,840	$120,841
	7	$0	$45,420	$45,421	$68,130	$68,131	$90,840	$90,841	$113,550	$113,551	$136,260	$136,261
	8	$0	$50,560	$50,561	$75,840	$75,841	$101,120	$101,121	$126,400	$126,401	$151,680	$151,681

Bert Nash CMHC provides the following services at the specified rates. Per the information you provided, your estimated rate is: (staff to circle rate)

	90% Discount	80% Discount	60% Discount	40% Discount	20% Discount	Full Fee
Intake	$15	$30	$60	$90	$120	$150
Individual Therapy	$16	$32	$64	$96	$128	$160
Group Therapy	$5	$10	$20	$30	$40	$50
Adult Psychosocial	$5	$10	$20	$30	$40	$50
Children's Respite	$5	$10	$20	$30	$40	$50
Medication Eval	$23	$45	$90	$135	$180	$225
Med Check (45-60 min)	$23	$45	$90	$135	$180	$225
Med Check (15-30 min)	$13	$25	$50	$75	$100	$125
Case Management	$14	$28	$56	$84	$112	$140
Targeted Case Mgmt	$6	$13	$25	$38	$50	$63
Peer Support Individual	$6	$13	$25	$38	$50	$63
Crisis Basic Attend Care	$9	$17	$35	$52	$70	$87
Crisis Intermediate BA	$18	$35	$70	$105	$140	$175
Crisis Advanced QMHP	$18	$35	$70	$105	$140	$175
Crisis Observation**	$40	$80	$120	$160	$200	$320
Crisis Stabilization**	$35	$70	$105	$140	$175	$280

**Rates for these services are based on a per diem/per day rate and do not follow the Discount %.

Your signature below acknowledges that the following information has been explained:

- The Bert Nash Center's Fee Schedule and fee policies have been explained to me.
- I have received a copy of the Bert Nash Center's, Client Handbook, which contains information about client's rights as well as financial and billing information. The Client Handbook is also accessible on the Bert Nash Center website https://bertnash.org
- The Bert Nash Center will bill my insurance or third-party payor at full cost for the service.
- Services not covered either by private insurance, Medicare, Medicaid, and/or Kansas Medical Card will be the responsibility of the individual, parent, and/or legal guardian.
- For out of network/non-covered providers, I will be charged according to the Bert Nash Center Fee Schedule.
- Bert Nash Center does not issue refunds for services rendered.
- I understand that I am to pay my determined/co-pay fee before each session at the time of check-in.
- If I have no out-of-network benefits or if I choose to see a provider not covered by my insurance, I will be expected to pay the determined Sliding Scale Fee Schedule amount due at each visit.
- I acknowledge I have been informed that the Bert Nash Center requires a 24-hour notice when canceling appointments.

By signing this form, I indicate that I understand and accept my financial responsibilities.

MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES:

SIGNATURE: _____ DATE: _____

☐ Client ☐ Parent ☐ Legal Guardian

PRINT: _____ CLIENT ID # _____