

Fee Agreement and Good Faith Estimate



Patient Name: _____

Patient Date of Birth: _____

No Surprises Act

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers including psychiatrists and therapists are required to notify patients of their federal rights and protections against “surprise billing.” The purpose of the Act and of this document is to protect you from unexpected medical bills.

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network psychiatrist or therapist (as we often are), if you are uninsured, or if you elect not to use your insurance.

In case any of these situations apply to you, we are required to provide you with a “Good Faith Estimate” of the cost of services to you. Doing so is particularly challenging in mental health care because it is difficult to predict the length of treatment and because patients have a right to decide how long they want to participate. Therefore, we describe below the fees that typically apply for the types of services we offer, including for your condition. Going forward, we can collaborate on a regular basis to determine how many sessions you may need.

As per our terms and our patient/provider agreement, all patients agree to pay the full rate unless otherwise negotiated before treatment begins or if in-network in which case they agree to pay their co-pay or co-insurance amounts and meet any necessary deductibles. If no payment is presented at the time of treatment, payment will be billed to the credit card we have on file. After the initial consultation, regular follow-ups are scheduled depending on clinical needs. If you are seeing one of our psychiatrists, then depending on your treatment plan and clinical discretion, the frequency of medication management appointments may range. Note that these rates will remain in effect for at least a year from the start date of treatment and in the event of a fee increase after that time, a new Fee Agreement will be presented.

Carissimi Mental Health & Wellness PLLC

Tax ID: 39-3574351, Group NPI: 1598649220

Carissimi Mental Health & Wellness PLLC

732 S 6th St

Ste N

Las Vegas, NV 89101

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Nicole Carissimi, PMHNP NPI: 1770199341

Rates:

\$325 per hour for the initial consultation (usually 1-1.5 hours), 10% due at time of booking

(Extended Sessions - Sessions longer than 60 minutes are prorated at \$81.25 per 15-minute increment)

\$200 / Medication Management (up to 25 minutes)

\$250 / Medication Management + Therapy (up to 50 minutes)

Expert consultation, including forensic or legal document review, and preparation of significant documentation is billed at \$325/hour.

Appearances In court, depositions, and scheduled time addressing legal matters out of the office: \$325/hr

- These fees apply to all American Psychiatric Association DSM-5 diagnoses and corresponding ICD-10 codes.
- I use diagnostic codes that are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done once or twice weekly, but sometimes more or less often.
- Most often therapy continues for six months, one year, or several years, but short-term, brief therapy for intercurrent issues is also common. As noted above, because of this variability, please ask me about what can be expected in your case.
- Most often medication management is done every one to three months, but sometimes more often at the beginning of treatment and during periods of acuity, and sometimes less often.
- Most often medication management continues for several years or even longer; because of this variability, please ask me what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy.

Forms & Administrative Requests

Requests for completion of forms or administrative documents (including but not limited to FMLA, disability, workplace or school accommodations, emotional support animal letters, and other third-party paperwork) are not covered by insurance and require additional time outside of scheduled appointments.

Fees are based on the time and complexity involved:

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- **Brief/simple forms (≤10 minutes): \$25**
- **Moderate forms (10–20 minutes): \$50**
- **Complex forms (20–30 minutes): \$75**
- **Extensive or detailed documentation (30+ minutes): \$100+ (may be billed hourly if needed)**

An appointment may be required for certain requests to ensure accurate and appropriate completion.

All requests must be submitted in advance. Completed forms are typically returned within **5–10 business days**. Expedited processing may be available for an additional fee.

Completion of forms reflects clinical judgment and does not guarantee approval or outcome by the requesting agency or organization.

Required Disclaimers:

- Should you have additional questions about your rights under this act, you can contact any of the following: The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit <<https://www.cms.gov/nosurprises>> for more information about your rights under federal law. The Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431.
- If you are billed for more than this Good Faith Estimate you have the right to dispute the bill. You may 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 days (about 4 months) of the date on the original bill.
- There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider, you will have to pay the higher amount.

If you have any questions related to billing, please contact us via the Charm messaging system or speak to your clinician.

By signing this form, you agree to pay the full fee at the time of your treatment, unless otherwise arranged.

It is a federal requirement that each patient sign this form annually to begin/continue treatment.

Signature: _____

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Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

Date: _____

Clinician Signature: _____

Clinician Printed Name: _____

Date: _____