JESSA ZIMMERMAN MA

FEE AGREEMENT AND GOOD FAITH ESTIMATE OF CHARGES

Appointments are either 50 minutes or 80 minutes long and are billed at the rate of:

Counseling sessions: $200 for 50 minutes, $320 for 80 minutes

Any work pertaining to legal proceedings: $500 per hour

Rates are subject to change; they are evaluated periodically and may be adjusted up to 10%.

Good Faith Estimate of Charges:

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Based upon a fee of $200 per 50 minute visit, if you attend one psychotherapy visit every other week, your estimated charge would be $400 for two visits provided over the course of one month; $800 for four visits over two months; or $1200 for 6 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Based upon a fee of $320 per 80 minute visit, if you attend one psychotherapy visit every other week, your estimated charge would be $680 for two visits provided over the course of one month; $1280 for four visits over two months; or $1920 for 6 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Service Codes: Diagnosis code Z63.0 for relational distress; CPT service code: 90847 family/couple therapy with the patient present.

Cancellation: You are asked to cancel any appointment at least 48 hours in advance. The full session fee will be charged for missed appointments and cancellations with less than 48 hour notice. Exceptions may be made, at my discretion, for emergencies.

Delinquent Payment: You are responsible for your account and are expected to pay for all services you receive.

Insurance: I do not take insurance directly. Keep in mind that ***most insurance does not cover couples counseling*** (a "Z code" diagnosis of relational distress). I can provide the receipt you would need for out of network reimbursement for our work together if your insurance does cover a diagnosis of Z63.0. Please ask me if you would like a receipt. It is up to you to check with your insurance plan about possible reimbursement for out of network services. If your company requests more information than is provided on the receipt, I will provide a brief summary of treatment and an explanation of why further treatment would be beneficial; I will not provide a treatment plan or therapy notes. You retain ultimate responsibility for payment for services if your insurance company decides that this documentation does not meet their requirements for coverage of your treatment.

Sessions end on time, even if we are in the middle of something. This allows me to be on time for all of my clients.

Emergency and professional consultation telephone sessions are billed at the same rate, in quarter hour segments, after the first 5 minutes.

This contract is exclusively with Jessa Zimmerman, MA. (TIN 46-5669324, NPI # 1710264122) My work with you is as an independent practitioner and not in affiliation with any group practice, or other practitioner in this, or any other, building. Individual mental health practitioners assume no liability or responsibility for any other practitioner or group working in this office or building.

I (we) agree to pay the fees as listed above per psychotherapy session with Jessa Zimmerman, MA.

Having read the above contract, I understand my responsibilities for payment. My (our) signature(s) confirms acceptance of the above items and constitutes informed consent for psychotherapy without exception.

_____	_____	_____
Name (Print) and birth date	Client Signature	Date
_____	_____	_____
Name (Print) and birth date	Client Signature	Date