

## Healing Steps Family Therapy, LLC

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### PART A — Notice to Uninsured and Self-Pay Clients

#### **You have the right to receive a “Good Faith Estimate” explaining how much your health care will cost**

Under the law, health care providers need to give patients who don’t have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit

[www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 1-800-985-3059.

Source: CMS model notice, “Right to Receive a Good Faith Estimate of Expected Charges” under the No Surprises Act (Public Health Service Act §2799B-6; 45 CFR 149.610), <https://www.cms.gov/files/document/appendix-1-standard-notice-right-receive-good-faith-estimate-expected-charged-under-no-surprises-act.pdf> (same text as CMS sample notice rev. 8/2023, <https://www.cms.gov/files/document/nsa-gfe-required-notice.pdf>).

At Healing Steps Family Therapy, LLC, this applies to everyone paying privately, including all couples therapy clients starting January 1, 2027 (current insured couples starting April 1, 2027, after a 90-day grace period), all family therapy clients starting January 1, 2027, and individual clients who are uninsured or choose not to use insurance. To request an estimate, call (702) 743-4497 or email [stephen@healingvegas.com](mailto:stephen@healingvegas.com).

## PART B — Good Faith Estimate for Health Care Items and Services

Based on the CMS standard form "Good Faith Estimate for Health Care Items and Services" (<https://www.cms.gov/files/document/good-faith-estimate-example.pdf>). Required contents: 45 CFR 149.610(c).

### Patient

|                                                                                                    |                  |
|----------------------------------------------------------------------------------------------------|------------------|
| Patient name:                                                                                      | Date of birth:   |
| Patient name (partner 2, couples):                                                                 | Date of birth:   |
| Phone / Email (preferred delivery: <input type="checkbox"/> paper <input type="checkbox"/> email): | Date GFE issued: |

### Primary service

Description: ☐ Couples psychotherapy (private pay) ☐ Individual psychotherapy (self-pay) ☐ Family psychotherapy (private pay) ☐ Other: \_\_\_\_\_

Period of care covered by this estimate: \_\_\_\_\_ to \_\_\_\_\_. Scheduled date(s), if known:

\_\_\_\_\_

### Convening provider

|                           |                                                                                   |
|---------------------------|-----------------------------------------------------------------------------------|
| Provider/Facility name    | Healing Steps Family Therapy, LLC                                                 |
| Provider type             | Outpatient behavioral health group practice                                       |
| Address                   | 3175 E. Warm Springs Rd., Suite 111, Las Vegas, NV 89120                          |
| Contact / Phone / Email   | Stephen M. Stepanovich, MS, LMFT, CEO • (702) 743-4497 • stephen@healingvegas.com |
| Group NPI (Type 2)        | 1841105103                                                                        |
| Taxpayer ID (EIN)         | 47-2053458                                                                        |
| Rendering clinician & NPI | _____ / NPI _____                                                                 |

### Details of services and items

| Service/Item                                                        | Address where provided | Diagnosis code (if required for calculation) | Service code    | Quantity | Expected cost               |
|---------------------------------------------------------------------|------------------------|----------------------------------------------|-----------------|----------|-----------------------------|
| Couples session, standard (60 min)                                  | Office or telehealth   | Not required                                 | CPT 90847       | ___      | \$200 × ___ = \$___         |
| Couples session, 90 minutes                                         | Office or telehealth   | Not required                                 | CPT 90847       | ___      | \$250 × ___ = \$___         |
| Individual session (self-pay)                                       |                        |                                              | CPT 90834/90837 | ___      | \$150 × ___ = \$___         |
| Family session (private pay from 1/1/2027)                          | Office or telehealth   |                                              | CPT 90847/90846 | ___      | \$200 × ___ = \$___         |
| Letters, record requests, or court-related work (only if requested) |                        |                                              | N/A             | ___ hrs  | \$50 per hour × ___ = \$___ |

Total expected charges from Healing Steps Family Therapy, LLC: \$\_\_\_\_\_

Late-cancellation and no-show fees are not part of this estimate; they apply only if a session is missed or cancelled late (\$100 late cancel; \$105 (\$100 no-show fee + \$5 card processing fee) no-show; \$200 no-show for a 90-minute couples session). The standard no-show fee includes a \$5 card processing fee.

Additional provider notes: \_\_\_\_\_

Items/services expected to be scheduled separately with another provider (e.g., psychiatry, psychological testing):  
\_\_\_\_\_ — separate estimates will be issued by those providers upon scheduling or request.

## Disclaimer

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.

There is a \$25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the \$25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 1-800-985-3059.

**Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.**

*Disclaimer text: verbatim from CMS standard GFE template, <https://www.cms.gov/files/document/good-faith-estimate-example.pdf>.*

\_\_\_\_\_  
Client acknowledgment of receipt (optional)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

— Printed name