PEREZ MOON PEREZ
PSYCHOTHERAPY & FAMILY COURT SERVICES

"Good Faith Estimate"

Psychotherapy and Family Court Services
6700 Indiana Avenue, Suite 110
Riverside, CA 92506
(951)369-9990

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

- **You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.**
- **Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.**
- **You have the right to receive the Good Faith Estimate in a language you understand.**
- **If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.**
- **Make sure to save a copy or picture of your Good Faith Estimate.**

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (951)369-9990.

Surprise Billing Protection Form – Good Faith Estimate

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one. See the next pages for your cost estimate.

Patient Name:_____

Patient Date of Birth: _____

Out-of-network provider(s)or facility name:

☐ Claudia S. Perez, MS, LMFT 31370

☐ Robert Perez, MS, LMFT 28017

☐ Jennifer Simmons, MS, LMFT 34926

☐ Katherine Hall, MS, ALMFT 109169

☐ Psychotherapy and Family Court Services

EIN: _____ NPI: _____

Total cost estimate of what you may be asked to pay:

►Review your detailed estimate on Pages 6-10 of this document. There you will find a list of our services and the associated cost estimate for each service you may participate in.
►Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
►Questions about this notice and estimate? Call our office at (951)369-9990.
►Questions about your rights? You can review your rights at:
https://www.cms.gov/nosurprises/consumer-protections/What-are-the-new-protections

Dispute resolution organizations can be located at: https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

Prior authorization or other care management limitations: Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit https://www.cms.gov/nosurprises/consumer-protections/What-are-the-new-protections for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ Claudia S. Perez, MS, LMFT 31370

☐ Robert Perez, MS, LMFT 28017

☐ Jennifer Simmons, MS, LMFT 34926

☐ Katherine Hall, MS, ALMFT 109169

☐ Psychotherapy and Family Court Services

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____

Patient's signature — Guardian/authorized representative's signature

_____ _____

Print name of patient — Print name of guardian/authorized representative

_____ _____

Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form. It contains important information about your rights and protections.

PEREZ MOON PEREZ
PSYCHOTHERAPY & FAMILY COURT SERVICES

"Good Faith Estimate"

Detailed Estimates of the Cost of Services

Patient Name:_____

Patient Date of Birth:_____

Out-of-network provider(s)or facility name:

☐ Claudia S. Perez, MS, LMFT 31370

☐ Robert Perez, MS, LMFT 28017

☐ Jennifer Simmons, MS, LMFT 34926

☐ Katherine Hall, MS, ALMFT 109169

☐ Ashley Saldana, MS, LCSW 101444

☐ Psychotherapy and Family Court Services

EIN: _____ NPI: _____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. **This means that the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Date of Service (if known)	**Service Code**	**Description**	**Estimated Amount to be billed**
Every other week Estimated 24 sessions per year Estimate 50 sessions per year	**90837/ 90834**	Psychotherapy session: $180.00 initial/ $160.00	$3,860.00 (24 sessions) $8,020.00 (50 sessions)
Every other week Estimated 24 sessions per year	**CourtCase**	Standard Court Case: $200.00/session. This includes reunification therapy and any other	$4,800 (24 sessions) $10,000 (50 sessions)

Estimate 50 sessions per year		court-ordered therapy sessions.	
Every other week Estimated 24 sessions per year Estimate 50 sessions per year	**INTERN**	Intern Clinical Sessions: $50.00/session with Katherine Hall	$1,200.00 (24 sessions) $2,500.00 (50 sessions)
Emergency/Crisis Session Estimated 2 events per year	**90839**	Up to 60-minute emergency session with less than 24 hours' notice or after hours. $200.00	$400.00 for the year
Semi-Weekly for 10+ weeks	**COPAR**	Individual Co-parenting with Claudia Moon Perez	$2,000.00 (+ $200 per additional session)
Weekly for 10 weeks	**INTERNCLASS**	Co-Parenting/Parenting Class: $50.00/class x 10 class sessions with Katherine Hall	$500.00 for the year
Process Includes: 1. Intake (2 hours) 2. Interviews (approximately 10 hours) 3. Assessment Testing (2 hours) 4. Documentation Review (charged $5/page beyond 50 pages) 5. Writing/Editing (approximately 20 hours)	**3111**	**FC 3111 Child Custody Evaluation:** $4,500.00 – ($3,500.00 retainer + $1,000.00 non-refundable administrative fee.) This retainer covers the first 14 hours of service. Additional hours will be subsequently charged at an itemized rate of $250.00/hour. Does not include psychological testing. Reports are not disbursed to court/attorneys/proper clients until full payment is received.	Approximated Total Charge: $8,500.00

		Delays in payment are documented in the report.	
Process Includes: 1. Intake (2 hours) 2. Interviews (approximately 10 hours) 3. Assessment Testing (2 hours) 4. Documentation Review (charged $5/page beyond 50 pages) 5. Writing/Editing (approximately 25 hours)	**3118**	**FC 3118 Child Sexual Abuse Evaluation:** $6,500.00 – ($5,500.00 retainer + $1,000.00 non-refundable administrative fee.) This retainer covers the first 22 hours of service. Additional hours will be subsequently charged at an itemized rate of $250.00/hour. Reports are not disbursed to court/attorneys/proper clients until full payment is received. Delays in payment are documented in the report.	Approximated Total Charge: $9,750.00
Process Includes: 1. Intake (2 hours) 2. Interviews (approximately 10 hours) 3. Assessment Testing (6 hours) 4. Collateral Contacts (approximately 4 hours) 5. Documentation Review (charged $5/page beyond 50 pages)	**730**	**EC 730 Child Custody Evaluation:** **$**8,000.00 – ($7,000.00 retainer + $1,000.00 non-refundable administrative fee.) This retainer covers the first 28 hours of service. Additional hours will be subsequently charges at an itemized rate of $250.00/hour. Includes psychological testing.	Approximated Total Charge: $13,500.00

6. Writing/Editing (approximately 30 hours)		Reports are not disbursed to court/attorneys/proper clients until full payment is received. Delays in payment are documented in the report.	
Process Includes: 1. Intake (2 hours) 2. Interviews (approximately 10 hours) 3. Assessment Testing (2 hours) 4. Documentation Review (charged $5/page beyond 50 pages) 5. Writing/Editing (approximately 20 hours)	**730 Supplemental**	**$**6,000.00 – ($5,000.00 retainer + $1,000.00 non-refundable administrative fee.) This retainer covers the first 20 hours of service. Additional hours will be subsequently charged at an itemized rate of $250.00/hour. Reports are not disbursed to court/attorneys/proper clients until full payment is received. Delays in payment are documented in the report.	Approximated Total Charge: $8,500.00
Process Includes: 1. Individual session per each party 2. Joint session with both parties 3. Documentation review 4. One "Ground rules" session 5. $250/hour thereafter.	**Parenting Plan Coordinator/ Special Master**	$3,000.00 – ($1,500 each party). This retainer is for the first 12 hours of service.	Approximated Total Charge: $3,000.00
Process Includes: 1. Intake session 2. Opposing session	**Court Ordered Substance Abuse Assessment**	$1,750.00 – ($1,250.00 retainer + $500.00 non-	Approximated Total Charge: $1,750.00

3. Testing session 4. Results session 5. Writing		refundable administrative fee). Additional hours over the 5 sessions will be charged at $250.00/hour.	
Total estimate of what you may owe:			

DISCLAIMER: These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length, or cost. Your signature does not require you to receive psychotherapy services from our offices.