INTEGRATED WELLNESS AND STRATEGIES, LLC
Amber W. Pearson, MA, LPC, EMDR-CT
Your path to healing and transformational growth...

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SELF-PAY GOOD FAITH ESTIMATE AGREEMENT

The Full Service Rate at Integrated Wellness and Strategies, LLC for Individual Therapy sessions is $120 for 50 minutes, $130 for 60 minutes, and $160 for 90 minutes of Individual Therapy. The Full Service Fee for Intake Sessions is $130. Please note that these fees are based only on service type. Below is the Base Sliding Scale Rates chart for 60 minute sessions for whom these fees are not financially viable:

Total Household Income Range	Number per Household						
	1	2	3	4	5	6	7+
$0 to $40,000	$80	$80	$80	$80	$80	$80	$80
$40,000 to $45,000	$85	$80	$80	$80	$80	$80	$80
$45,000 to $50,000	$90	$85	$80	$80	$80	$80	$80
$50,000 to $55,000	$95	$90	$85	$80	$80	$80	$80
$55,000 to $60,000	$100	$85	$90	$85	$80	$80	$80
$60,000 to $65,000	$105	$100	$95	$90	$85	$80	$80
$65,000 to $70,000	$110	$105	$100	$95	$90	$85	$80
$70,000 to $75,000	$120	$110	$105	$100	$95	$90	$85
$75,000 to $80,000	$125	$120	$110	$105	$100	$95	$90
$80,000 to $85,000	N/A	$125	$120	$110	$105	$100	$95

By checking the following two boxes and initialing below you agree to *either* pay the Full Service Rate ***or*** your Base Sliding Scale Rate (based on the above Sliding Scale Rates chart).

☐ Agree to pay the Full Service Rates as follows (if the Sliding Scale Rates do not apply or to receive insurance reimbursement):

- o $130 for 60 minutes of Individual Therapy
- o $140 for Intake
- o $120 for 50 minutes of Individual Therapy
- o $100 for 30 minutes of Individual Therapy
- o $160 for 90 minutes of Individual Therapy

Initials_____

OR

☐ Agree to pay the following for Individual Therapy sessions based on the Base Sliding Scale Rate:

- o _____per 60 minutes of Individual Therapy from the Base Sliding Scale Rate.
- o _____per Intake (*Add $10 to the Base Sliding Scale Rate*).
- o _____per 50 minutes of Individual Therapy (*Subtract $10 from the Base Sliding Scale Rate*).
- o _____per 30 minutes of Individual Therapy (*Subtract $30 from the Base Sliding Scale Rate*).
- o _____per 90 minutes of Individual Therapy (*Add $30 to the Base Sliding Scale Rate*).

Initials_____

- Recognize that these service fees are subject to change due to cost of living increases. If these fees are going to change, Integrated Wellness and Strategies, LLC will inform you at least a month prior.

Initials_____

- Understand that we will review your financial circumstances at the beginning of each year to determine whether your fee per session needs to be readjusted. Unless this occurs, these fees will remain the same.

Initials_____

- Understand that if you become insured and/or your financial circumstances change, you will notify me within one month so that we may either begin billing your insurance company or readjust your fee per session. Unless this occurs your fees remain the same.

Initials_____

In addition, by initialing below you agree to:

- Recognize that it is a standard for Integrated Wellness and Strategies, LLC to meet with clients for 60 minute Individual Therapy sessions either weekly or every other week. The frequency of sessions, length of sessions, and length of treatment depends on a variety of factors (ex: presenting concerns, diagnoses, desired frequency of sessions, type of treatment being sought (short-term versus long-term), etc. Depending on the amount of progress we are able to make together, I typically meet with clients who are seeking short-term therapy for 3-6 months, and those seeking longer-term treatment, for 1-4 years or longer depending on their needs. This will subject to change depending on your needs. With this understanding the following can be expected:
    - If we meet once per week, the monthly cost would be_____ based on a rate of_____per 60 minute Individual Therapy session (assuming there will be 4 sessions in a month).
    - If we meet every other per week, the monthly cost would be_____ based on a rate of _____ per 60 minute Individual Therapy session (assuming there will be 4 sessions in a month).

By signing below, you agree that you have read, understand, and agree to pay the amounts specified above, in accordance to this SELF-PAY GOOD FAITH ESTIMATE AGREEMENT:

Client Name (printed)	Client Signature	Date

Disclaimer: This Self-Pay 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 Self-Pay 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, federal law allows you to dispute (appeal) the bill.

Right to Dispute: If you are billed for more than this Self-Pay Good Faith Estimate, you have the right to dispute the bill. Please contact Amber W. Pearson directly if this occurs. She can be contacted via the following methods:

Phone: 720-644-6378
E-mail: amber@strategiesintegrated.com

☐ Copy provided to client.