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Good Faith Estimate For Health Care Services – IOP 2025

(estimates include services conducted in person or virtually)

Primary Service or Item Requested/Scheduled:	IOP
Patient Primary Diagnosis and Diagnosis Code:	Illness, unspecified - R69

Expiration Date: 12/31/2025

If fees change, a new Good Faith Estimate will be provided.

Contact Person: Kim Mueller, Office Manager
Phone: 440 392 2222 #303
Email: Kmueller@behavioralwellnessgroup.com
Facility National Provider Identifier: 1467872689
Facility Taxpayer Identification Number: 46-5078878

Summary of Expected Charges

Primary Service Being Provided:	IOP - Prepaid (non-refundable)
Frequency:	One Time 24 Session Charge
Unit Price:	$3500
Total Anticipated Per Year:	$3500

Primary Service Being Provided:	IOP - Pay by Session
Frequency:	3 Times per week
Unit Price:	$165 per session
Total Anticipated Per Year:	$165 over 24 sessions = $3960

Total Estimated Yearly Cost of Treatment:	$3500-$4000, subject to change according to needs

**** Reports/Records requests will be completed for a fee that will be discussed ahead of time based on the particular request and information needed but typically 50.00 per request.**

Additional Services

Additional Services which are not reflected in this good faith estimate may be required as your treatment progresses. These will always be discussed with you and fully detailed ahead of the service being provided. Some of these services include but are not limited to:

Reports/Records requests will be completed for a fee that will be discussed ahead of time based on the particular request and information needed.

Fees for Psychological Testing -- complete estimates will be provided and discussed within 1 business day of the testing battery beginning. It will be based on the particular tests/reports/materials and facility charges needed to complete the testing battery. You will be provided a copy of the BWG Psychological Testing Agreement form.

Intensive Outpatient Programs (IOPs) -- complete estimates will be completed and discussed ahead of time. You will be provided a copy of the BWG IOP Consent for Treatment form.

Psychiatry Fees have been provided in the signed BWG MEDICAL SERVICES POLICIES AND PROCEDURES-PATIENT STATEMENT OF UNDERSTANDING.

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, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you 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.

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 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

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

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.

Patient Name:_____ Date of Birth:___/_____/_____

Signature of Patient or Responsible Party:

_____

Date:

___/_____/_____