8224 Mentor Ave #208, Mentor, OH 44060
Toll Free: 888 996 9374 • Office: 440 392 2222 • Fax: 440 565 2349
www.behavioralwellnessgroup.com

Good Faith Estimate for Health Care Services 2025

Primary Service(s) Requested:

Please choose one:

- ○ Individual Therapy
- ○ Couples Therapy
- ○ Family Therapy
- ○ Psychological Testing
- ○ Group Therapy

Primary Diagnosis and Diagnosis Code: Illness, Unspecified - R69

Expiration Date: 12/31/25

If fees change during this time, 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: 146872689
Facility Taxpayer Identification Number: 46-5078878

Summary of Expected Charges

Primary Service Being Provided:	Initial Evaluation
Frequency:	Max 2 sessions
Unit Price:	$200 per session
Total anticipated per year:	Max $500

Primary Service Being Provided:	Individual Session (53-67 minutes)
Frequency:	Assumed Weekly
Unit Price:	$150 per session
Total anticipated per year:	**Only if meeting every week, $7800**

Primary Service Being Provided:	Individual Session (38-52 minutes)
Frequency:	Assumed Weekly
Unit Price:	$100 per session
Total anticipated per year:	**Only if meeting every week, $5200**

Primary Service Being Provided: Psychological Testing

For Adults 18+:

- ○ ADHD - $3400 base max fee, $5200 with IQ test added
- ○ Learning Disability Test - $4400 base max fee, $5600 with ADHD test added

- ○ Bariatric or Pain Assessments - $2300 base max fee, $3800 if additional testing needed
- ○ Autism Spectrum Disorder - $2600 base max fee, $3800 with ADHD, $4600 with ADHD and LD testing
- ○ IQ Testing - Maximum $3000
- ○ Gender Affirming Surgery - $2300 base max fee, $3200 with other testing added
- ○ None

For Child/Adolescent (Ages 5-17):

- ○ ADHD - $3400 base max fee, $4800 with IQ test added
- ○ Learning Disabilities Test - $4800 base max fee, $5600 with ADHD test added
- ○ Autism Spectrum Disorder - $3200 base max fee, $4000 with ADHD added, $5000 with ADHD and LD added
- ○ IQ Testing - Maximum $3400
- ○ None

**** 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 with 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 with 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: ___/_____/_____