Wellbeing
COUNSELING & WELLNESS

CLIENT RIGHTS TO A GOOD FAITH ESTIMATE OF SERVICES

Updated August 1st, 2022

Dear Wellbeing Clients,

In compliance with the No Surprises Act effective January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against “surprise billing.”

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a client is uninsured, or if a client elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services (please see the “Service Rates” below). It is difficult to determine the true length of treatment for mental health care, and each client has a right to decide how long they would like to participate in mental healthcare. However, below is a fee schedule for the services typically offered by the Wellbeing Collective. We will collaborate with you on a regular basis to determine how many sessions you may need.

If you have any additional questions, please don’t hesitate to ask.

Sincerely,

Melody Ott (LCSW), Jill Meehan (LCSW), Maren Villavisanis (LCSW)
Founding Therapists at Wellbeing Counseling and Wellness
101 Whitehall Drive, Suite 107, St. Augustine, FL 32086

SERVICE RATES

Individual Therapy
Individual therapy is customized to meet your needs and goals and is 50 minutes in length.
$150

Couples Counseling
Counseling for couples who are dating, engaged or married are 50 minutes in length.
$150-$160

Family Counseling
Group counseling for all of the members of your family. Sessions are 50 minutes in length.
$150

Child-Centered Therapy
Counseling for individual children in your family. Play therapy sessions are 50 minutes in length.
$150

Teen DBT Group Therapy
Group sessions for teens during the fall and spring.
$60 per session

Mindfulness and Yoga Group Therapy
Group sessions offered several times throughout the year.
$60 per session

Positive Parenting Support Group
Workshops offered several times throughout the year.
$60 per workshop

Family Grief Support Group
Family grief support group meets once per month.
$100 per family per session

Telehealth
Telehealth follows the same fee schedule as in-person therapy sessions.
$150 for individual therapy and $60 for group therapy.

Adoption Home Study and Post Placement
This fee includes the $200 application fee and post placement visit. Not included is the cost of any medical examinations and fingerprinting clearances.
$1,800

Court Forms
If you require a treatment summary or any other documentation for court, we are happy to help. Each document is treated as a separate item.
$500

Legal Engagement
While we do not offer legal engagement as part of our services, if one of our therapists is subpoenaed to court, a flat daily fee will apply.
$2,000/day

Late Cancellation Fee
Your therapist requires a 24-hour notice for cancellation. Clients who fail to provide a full 24-hour notice will be responsible for the full fee of their missed appointment.

Returned Checks
$40

Fees Related to Credit Card Disputes
$40

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan’s in- network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

1. **Cover emergency services without requiring you to get approval for services in advance (prior authorization).**

2. **Cover emergency services by out-of-network providers.**

3. **Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.**

4. **Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.**

If you believe you've been wrongly billed, you may contact:

Wellbeing Counseling and Wellness by calling 904-553-9283.

The Florida Board of Health: The Health Care Complaint Portal allows consumers to file a complaint with the appropriate state agency. You will be asked a series of questions to help identify the nature of your complaint. After you have answered all of the questions, you will see a summary page with instructions on how to file your complaint.
Visit https://www.cms.gov/nosurprises.