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

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SELF-PAY GOOD FAITH ESTIMATE FORM

The Full Service Rates at Integrated Wellness and Strategies, LLC for Individual Therapy sessions is $130 for 50 minutes, $140 for 60 minutes, and $170 for 90 minutes. The Full Service Rate for an initial Intake Session is $150. Please note that these fees are based only on service type. Below is the Base Sliding Scale Rates Chart based on 60 minute Individual Therapy sessions:

Base Sliding Scale Rates Chart

Total Household Income Range	Number per Household					
	1	2	3	4	5	6 +
$0 to $45,000	$105	$100	$100	$100	$100	$100
$45,000 to $50,000	$105	$105	$100	$100	$100	$100
$50,000 to $55,000	$110	$105	$105	$100	$100	$100
$55,000 to $60,000	$110	$110	$105	$105	$100	$100
$60,000 to $65,000	$115	$110	$110	$105	$105	$100
$65,000 to $70,000	$120	$115	$110	$110	$105	$105
$70,000 to $75,000	$125	$120	$115	$110	$110	$105
$75,000 to $80,000	$125	$125	$120	$115	$110	$110
$80,000 to $85,000	$130	$125	$125	$120	$115	$110
$85,000 to $100,000	$135	$130	$125	$125	$120	$115

By checking one of the following two boxes and initialing below I agree to *either* pay the Full Service Rate ***or*** the Base Sliding Scale Rate (based on the above Base Sliding Scale Rates Chart). I understand that if I am planning to use services of IWS, LLC via the Self-Pay Out-of-Network Option, paying the Full Service Rate is required and a Superbill will be provided for submission purposes:

☐ I agree to pay the Full Service Rate as follows:

- $140 for 60 minutes of Individual Therapy
- $150 for Intake
- $130 for 50 minutes of Individual Therapy
- $110 for 30 minutes of Individual Therapy
- $170 for 90 minutes of Individual Therapy

In utilizing the Full Service Rate, I plan to use the following Self-Pay Type:
☐ Self-Pay Out of Network Option
☐ Self-Pay Non-Insurance Option

OR

☐ I agree to utilize the Self-Pay Non-Insurance Option and to pay the following for sessions based on the Base Sliding Scale Rates Chart:

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

In accordance to the rate agreement above, please check and/or complete the following boxes:

☐ I recognize that it is a standard for Amber W. Pearson 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, etc). Depending on the amount of progress we are able to make together, Amber W. Pearson will 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. Length and frequency of therapy is subject to change depending on client needs. With this understanding the following can be expected based on your chosen rate (either Full Service Rate *or* Base Sliding Scale Rate):

- 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 2 sessions in a month).

☐ I 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 me at least a month prior.

☐ I understand that we will review my financial circumstances at the beginning of each year to determine whether my fee per session needs to be readjusted. Until then, these fees will remain the same.

☐ I understand that if I become insured and/or my financial circumstances change, I will notify Amber W. Pearson within one month to assess whether adjustments need to occur. Until then, these fees will remain the same.

By signing below I certify that I have read, understand, and consent to pay the amounts specified above, in accordance to this Self-Pay Good Faith Estimate Form:

_____

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