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Tax ID: 26-2221421

GOOD FAITH ESTIMATE
FEES & FINANCIAL POLICIES

Table with 2 columns and 2 rows: Patient Name, Date of Birth, Provider Name, Today's Date

The purpose of this document is to make sure that you are fully informed about our fees and financial policies and to comply with a 2022 federal law called the "No Surprises Act." The intention of this law is to protect consumers from large, unexpected medical bills (e.g., after a hospital visit) in the wake of the COVID-19 pandemic.

This estimate is not intended to serve as a recommendation for treatment or a prediction that you may need a specified number of psychotherapy sessions. Indeed, it is not possible for us to know in advance precisely what services you may need or how many sessions may be required.

\*\*\*NOTE: This estimate expires at the end of the current calendar year.\*\*\*

General Fees:

- For all new patients, the first session is a 90-minute clinical interview and costs:
- \$340 for doctoral-level providers (Drs. Sodergren, Dowdell, & Murphy)
- \$280 for masters-level providers (Rod Dunlap, MA, IMFT; Alex Wallace, MA, LPCC)
Subsequent, standard length (45-50 min.) sessions of individual, marital, or family therapy cost:
- \$170 for doctoral-level providers (Drs. Sodergren, Dowdell, & Murphy)
- \$140 for masters-level providers (Rod Dunlap, MA, IMFT; Alex Wallace, MA, LPCC)
Some patients choose longer sessions (60-75 min.). These extended sessions cost:
- \$240 for doctoral-level providers (Drs. Sodergren, Dowdell, & Murphy)
- \$200 for masters-level providers (Rod Dunlap, MA, IMFT; Alex Wallace, MA, LPCC)
Group therapy sessions are 90 minutes in length and cost \$100 for all providers.
Psychological testing is generally billed at a rate of \$170 per hour.
We also reserve the right to charge a \$75 fee for no-shows or appointments cancelled with less than 24-hours' notice.

### **Ongoing Therapy Costs:**

Below are some examples of the potential annual cost for engaging in standard length sessions (45-50 min.) at monthly, bi-weekly, weekly, and twice weekly frequencies for a full year. Your actual costs will likely differ from these based on your individual needs.

#### Monthly

- 12 monthly sessions with a doctoral-level provider = \$2040
- 12 monthly sessions with a master-level provider: = \$1680

#### Biweekly

- 26 biweekly sessions with a doctoral-level provider = \$4420
- 26 biweekly sessions with a masters-level provider = \$3640

#### Weekly

- 52 weekly sessions with a doctoral-level provider = \$8840
- 52 weekly sessions with a masters-level provider = \$7280

#### Twice Weekly

- 104 twice-weekly sessions with a doctoral-level provider = \$17680
- 104 twice-weekly sessions with a masters-level provider = \$14560

### **Psychological Evaluation Costs:**

If a psychological evaluation including the administration, scoring, and interpretation of psychological tests is recommended, we will provide a separate Good Faith Estimate for your specific evaluation.

### **Payment:**

- Payment is due at the time of service. Please speak to the front desk or your therapist about payment before you leave the office. However, we prefer that our patients pay at the front desk before their sessions so that they do not have to re-enter the waiting area afterward.
- Our preferred methods of payment are cash and check.
- For your convenience, we also accept credit, debit, and HSA cards. However, Ruah Woods is a non-profit ministry, and you can help us avoid oppressive bank fees by paying with cash or check. This small inconvenience can result in enormous savings for the ministry. Thank you!
- If you pay with a bank card, our practice management software will save your information to speed future transactions. We will charge your card for subsequent visits unless you tell us not to do so. If your card information changes, please notify the front desk as soon as possible.
- We do not routinely allow patients to accrue an unpaid balance. If you happen to accrue a balance on your account, we will send an invoice to you. Please respond promptly.
- If you become unable to pay for services or begin to accrue a balance, discuss this with us as soon as possible. We will work with you to find a solution. If we are unable to come to an agreement, and you continue to maintain an unpaid balance, we reserve the right to terminate your services.

### **Insurance:**

RWPS does not participate in any insurance plans, Medicare, or Medicaid. We will not bill insurance companies nor accept reimbursement from them. However, our patients are free to submit their own claims to their health insurance company if they wish to pursue reimbursement for our services. We can provide only limited assistance in this process. For example, we can provide you with statements (called “Superbills” or “Flexible Spending Statements”) that list all the information insurance companies typically need to process a claim. These statements become available a few days after our services were rendered. It is your responsibility to send these statements to the claims department of your insurance company for processing. NOTE: Regardless of whether your insurance

company reimburses you, our fees are still your responsibility and payment is due in full at the time of service. Our policy is that the patient first pays Ruah Woods, and any reimbursement from the insurance company goes directly back to the patient.

**Charitable Grant Program:**

- For those who cannot otherwise afford our services, Ruah Woods is pleased to offer a Charitable Grant Program. These monetary Grants are given to a portion of qualifying RWPS patients and are used each session to offset the standard fees, effectively reducing the estimated costs listed above. In other words, once a per-session Grant amount is approved, it will be deducted from the standard fee for each session with the patient being responsible for the remainder. For example, if a patient seeing a doctoral-level provider for standard-length individual psychotherapy sessions (fee = \$170) is approved for a Charitable Grant of \$80 per session, his/her remaining fee would be \$90 (\$170 - \$80 = \$90). The remaining fee is always the patient’s responsibility and is due at the time of service.
- We have limited budget for Charitable Grants, and individuals interested in receiving a Grant must complete a brief application and provide verification of family size and current income. The amount of the Grant is subject to approval and varies depending on the needs of the individual and the availability of funds. Please let us know if you have questions about our Charitable Grant Program or would like to apply.

**Your Rights:**

We encourage you to discuss with your therapist any questions you might have about our fees and financial policies. In addition, according to the No Surprises Act, you have a right to dispute your bill if the actual amount charged to you substantially exceeds (i.e., by \$400 or more) the estimated charges stated in this Good Faith Estimate. Initiating the dispute process will not adversely affect the quality of services rendered to you. To do so, simply discuss the discrepancy with your therapist and point out that the billed charges are higher than the Good Faith Estimate. You have several options:

- Ask that your bill be brought in line with the Good Faith Estimate
- Ask to negotiate the bill
- 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 this option, you must start the dispute resolution 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, 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](http://www.cms.gov/nosurprises) or call HHS at 800-368-1019. We encourage you to keep a copy of this Good Faith Estimate for your records.

**Informed Consent**

By signing below, I acknowledge that I have received and read the RWPS Good Faith Estimate / Fees & Financial Policies document. My signature further signifies that I am freely giving my informed consent to the terms described herein.

\_\_\_\_\_  
(Print Patient Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient or Parent/Legal Guardian)

\_\_\_\_\_  
(Relationship to Patient)