Be My Neighbor Counseling

Fee Disclosure & Good Faith Estimate

Sliding-Scale Counseling Fees and Financial Agreement

Phone: 406-414-7011 | Email: bemyneighborcounseling@gmail.com

This document describes the expected counseling fee arrangement. It is intended to promote transparency and should be reviewed alongside any applicable billing, payment, insurance, or Good Faith Estimate requirements.

Sliding-Scale Fee

Be My Neighbor Counseling may offer a sliding-scale fee ranging from $5 to $50 per counseling session based on individual circumstances and availability.

Agreed Session Fee:	$_____ per session
Effective Date:	_____

Payment

Payment will be processed through the designated electronic health record (EHR) and payment system. Clients should keep their payment information current and communicate promptly about financial concerns.

Good Faith Estimate

When required by applicable law, clients who are uninsured or who are not using insurance may be entitled to receive a Good Faith Estimate of expected charges. A Good Faith Estimate is an estimate, not a guarantee of the total amount that will ultimately be charged, particularly when circumstances or the scope of services change.

Expected frequency of sessions: _____
Expected duration of services: _____
Estimated session fee: $_____
Estimated other anticipated charges, if any: _____

Changes in Financial Circumstances

Please communicate if your financial circumstances change. A revised fee arrangement may be considered when clinically and administratively appropriate.

Missed Appointments / No-Shows

If you need to cancel or reschedule, please communicate as soon as possible. After 3 no-shows without notification, you may receive a warning regarding attendance. After 5 total no-shows, services may be discontinued and you may be discharged from care. A $20 fee may be charged for each of the final two no-show appointments leading up to discharge, consistent with the agreed-upon fee policy.

Questions About Fees

Please contact 406-414-7011 or bemyneighborcounseling@gmail.com if you have questions about your fee arrangement or believe there is an error.

Client Acknowledgment

☐ I understand my agreed-upon session fee.

☐ I understand the general payment and missed-appointment policies.

☐ I understand that a Good Faith Estimate, when required, is an estimate of expected charges rather than a guarantee.

☐ I understand that I may ask questions about fees and payment at any time.

Client Name:	_____
Client Signature:	_____
Date:	_____

Supervision Information

I am currently a graduate student in a Mental Health Counseling program and provide services under clinical supervision. My supervisor's information is listed below.

Clinical Supervisor:	Onnie Michalsky
Professional License:	MA, EdS, LCPC, NCC
License Number:	LIC#38831
Supervising Organization/Practice:	DBA Mom’s Without Capes onnie@momswithoutcapes.com