NORTHERN LIGHTS PSYCHIATRY SERVICES

Good Faith Estimate of Expected Charges

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About this estimate
This document summarizes common self-pay charges for services offered by Northern Lights Psychiatry Services. Your actual services and total cost depend on your clinical needs, treatment plan, visit frequency, insurance status, and any additional services requested or recommended.

Psychiatric / Medication Management

Service	Typical Self-Pay Fee
Comprehensive Initial Psychiatric Evaluation	$300
Medication Management Follow-Up	$150

Psychotherapy / Counseling

Service	Typical Self-Pay Fee
Initial Therapy Assessment / Intake	$240
Therapy Follow-Up	$130

ADHD Evaluation & Testing

Service	Typical Self-Pay Fee
Comprehensive ADHD Initial Evaluation + QbCheck Testing	$650
Remote QbCheck Testing + Interpretation	$350

Interventional Psychiatry

Service	Typical Self-Pay Fee
Spravato Consultation / Evaluation	$350
Spravato Follow-Up / Treatment Review	$150
Spravato Treatment Session	Varies*
NeuroStar TMS Consultation / Evaluation	$350
TMS Mapping / Initial Treatment Planning	Varies*
TMS Treatment Session	Varies*
Ketamine Consultation / Evaluation	$350
Ketamine Injection or Infusion	Varies*

Other Services

Service	Typical Self-Pay Fee
Forms, letters, disability/FMLA documentation, or other non-routine administrative services	Fee may apply
Medical records	As permitted by law
Missed Appointment / Late Cancellation (<24 hours)	$125

* Variable interventional psychiatry charges depend on the treatment protocol, medication source, dose, required monitoring, insurance coverage, and/or authorization. A more specific estimate will be provided when the anticipated course of treatment is known.

Estimated Ongoing Cost

Behavioral health treatment varies by patient. For example, a self-pay patient receiving an initial psychiatric evaluation followed by 11 monthly medication-management follow-ups would have estimated first-year professional charges of **$1,950** ($300 initial evaluation + 11 follow-ups at $150 each), before additional testing, procedures, medications, or other services.

Psychotherapy costs depend on visit frequency. ADHD testing, Spravato, TMS, ketamine treatment, laboratory testing, prescriptions, and services performed by outside facilities are separate from routine psychiatric or psychotherapy visits and may result in additional charges.

Insurance and Self-Pay

If you have health insurance and elect to use it, Northern Lights Psychiatry Services may bill your plan when the practice and service are eligible for insurance billing. Your financial responsibility may include deductibles, copayments, coinsurance, non-covered services, or other amounts determined by your plan. Patients may also elect to self-pay for certain services. Some testing, administrative, and interventional services may not be covered by insurance.

An active payment method on file is required in accordance with practice financial policies. Payment arrangements for outstanding balances may be discussed with the billing department at **billing@northernlightspsychiatry.com**.

Important Information About This Estimate

This is an estimate and is not a contract or guarantee of final charges. Actual charges may differ if your clinical needs, treatment plan, or frequency of care changes. When reasonably possible, additional recommended services will be discussed with you before they are provided.

This estimate does not include charges billed independently by other healthcare professionals or facilities, including pharmacies, laboratories, hospitals, emergency departments, imaging facilities, or other outside providers.

For patients who are uninsured or not using insurance to pay for care, federal Good Faith Estimate protections may apply. If a bill from a provider or facility is at least $400 more than the Good Faith Estimate from that provider or facility, you may be eligible to use the federal patient-provider dispute resolution process.

Patient Name	_____
Date of Birth	_____
Estimated Treatment Period	_____
Anticipated Services / Frequency	_____
Estimated Total Charges	$ _____
Estimate Date	_____
Provider / Representative	_____