Expiration Date 12/31/2022

Name of Therapist

Phone number
Email
Mailing address:
NPI#
EIN#
Primary Service - Psychotherapy

Good Faith Estimate for Health Care Items and Services

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are **not** enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing**, upon request **or** at the time of scheduling health care items and services.

Patient:
Patient Date of Birth:
Patient Identification Number: N/A
Patient Mailing Address:
Phone Number:
Email Address:
Primary Service or Item Requested/ Scheduled:
Address where service/item will be provided:

Patient Primary Diagnosis Primary Diagnosis Code:
Patient Secondary Diagnosis Secondary Diagnosis Code:

Psychotherapy will be provided: (date) and (timeframe) thereafter or until there is a need/request to change frequency

Summary of Expected Charges:
Provider Name:
Estimated Total Cost:
How payments should be made:
When payment is due: Either prior to or immediately after each session.

The following is a detailed list of expected charges for [paperwork, late fee, missed sessions],
Paperwork (i.e. supportive animal)- $50
Missed sessions: $25
Less than 24hr cancelation $25
Late fee: $30

Disclaimer

This 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 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.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or 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 the dispute resolution process, you must start the dispute 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 and agrees with the health care provider or facility, 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 or call 877-696-6775

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 877-696-6775.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.