Good Faith Estimate Notice

Notice to clients and prospective clients:

The No Surprises Act effective January 1st, 2022, requires that health care providers provide an estimate of the expected charges for medical services, including psychotherapy services to clients or patients who do not have insurance or who are not using insurance.

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 have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider for a Good Faith Estimate before you schedule a service, or at any time during treatment. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can 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 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.

Your health care provider must give you a Good Faith Estimate within the following timeframes:

- If the service is scheduled at least three business days before the appointment date, the Good Faith Estimate must be provided no later than one business day after the date of scheduling;
- If the service is scheduled at least 10 business days before the appointment date, the Good Faith Estimate must be provided no later than three business days after the date of scheduling; or
- If the uninsured or self-pay patient requests a good faith estimate (without scheduling the service), the Good Faith Estimate must be provided no later than three business days after the date of the request.

The Good Faith Estimate is not a contract and does not require you to obtain the items or services from this provider.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059.

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. If you have questions or concerns, please let me know.

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Good Faith Estimate

Date of Good Faith Estimate

Patient Name:

Patient Date of Birth:

As of this date, it is estimated that we will meet throughout the year at the frequency of once per week. Please note that dependent on your circumstances we may choose to meet more or less often, which will impact this estimate. These figures may be an overestimate given the expectation that some weeks will be skipped (holidays, vacation, unplanned events/sickness, etc.) from therapy. Crisis support will increase your annual cost and cannot be predicted within this estimate due to the nature of the work we do together.

The frequency and duration is dependent on your individual needs and goals. A revised Good Faith Estimate may be provided at a later date due to an expected increase in sessions and/or change to a higher per session cost.

For new patients, the estimate below is the approximate cost that is likely for most new patients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs.

The following chart contains the common services. This chart below is customizable allowing changes to the "Quantity" of the various services shall you wish to make your own Cost Estimate determination.

As of this date, the following is your Good Faith Estimate.

Service	* Diag. Code	Service Code	Quantity	Cost per unit	(12) Month Expected Cost
Diagnostic Evaluation	F4323	**90791**	1	250.00	$ 250.00
Psychotherapy 16-37 Min.	F4323	**90832**	0	110.00	$ 0.00
Psychotherapy 38-52 Min.	F4323	**90834**	0	160.00	$ 0.00
Psychotherapy over 52 Min.	F4323	**90837**	51	220.00	$ 11,220.00
Family Psychotherapy with Patient	F4323	**90847**	0	240.00	$ 0.00
Family Psychotherapy without Patient	F4323	**90846**	0	240.00	$ 0.00
				Total (12) Month Estimated Cost	$ 11,470.00

*** Diagnosis Code subject to change following Diagnostic Evaluation.**

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known at the time the estimate was prepared.

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.