ACTS, Inc.

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License: 4210

GOOD FAITH ESTIMATE

Client Name:

Date/Time:

Client Name: **(required)**

Date of Birth: **(required)**

If you have scheduled services with me: I am required by the 2022 No Surprises Act to give you a Good Faith Estimate of the cost of treatment if you are self-pay for my services ... i.e., ***if you are uninsured or not using insurance for this care.***

NOTE: If you are using insurance for my services, this information serves to inform you of an estimate of fees in the event your insurance does not cover my services at any given time (e.g., if your diagnosis changes or your plan changes).

As a reminder, I only provide filing services for BCBS; if your insurance plan is with another carrier, I can provide a receipt for my services. If your insurance covers my services, your co-pay/co-insurance likely will be much less than the below estimate.

NEW clients (we have not met for an initial session): Since I have not yet evaluated your difficulties or symptoms, I must at this point defer your diagnosis AND estimate your course of treatment.

Diagnosis Code: R69 (diagnosis deferred until assessment completed)

ESTABLISHED clients (we have met for an initial session): Due to the general nature of this form, the diagnosis code below is a general mental health diagnosis used for the purposes of this good faith estimate to satisfy the requirements of the No Surprises Act.

Diagnosis Code:

F99 - Unspecified Mental Disorder (Provisional)

A more specific diagnosis is available to you upon request of Mariana Glass, LCMHC either in a session or by secure message in the Client Portal.

Estimated Cost of Services
This initial estimate below is valid for 12 months, and you are entitled to receive an update on this estimate at any time upon request.

Anticipated treatment schedule (estimated):

[Based on rates effective August 1, 2022]
One session of CPT 90791 (diagnostic evaluation) at $145.00 (N/A for Established Clients)

PLUS

Bi-weekly sessions of CPT 90837 (psychotherapy, 52+ minutes) for 12 months (26 sessions) at $125/session: $3250

OR
Monthly sessions of CPT 90837 (psychotherapy, 52+ minutes) for 12 months (12 sessions) at $125/session: $1500

Total Estimated Cost for Services:
Initial session plus bi-weekly sessions: $3395

Initial session plus monthly sessions: $1645

This is just a rough estimate. The duration of our work together can be longer or shorter depending upon your symptoms, your work between sessions, and your response to treatment.

Unless required by a court order (an extremely rare situation), you are free to discontinue treatment at any time, and free to discuss any other modifications to treatment modalities, frequency, or duration. You are ultimately in control of your own healthcare; I am just here to provide help at your request.

Location of treatment: All sessions will take place in my office at 7 Beaverdam Road, Suite 201 Asheville,

NC 28804 OR via secure telehealth video/platform (e.g., Doxy.me or VSee)

My identifying information:
Mariana R. Glass, MA, LCMHC
National Provider Identifier: Payor: 1508905399; Rendering: 1780723551
Tax ID number: 16-1760440

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 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, www.cms.gov/ no surprises or call 1-800-985-3059. 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.

Client Electronic Signature: **(required)**

Date: **(required)**