Root to Rise Psychological Services
330 North Grand Avenue, Suite C, Pullman, WA 99163
(754) 227-9480, DrJane@rtrpsych.com@, RTRPsych.com

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth:		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State,	Zip Code
Phone		
Email Address		
Patient's Contact Preference:	[ ] By mail	[X] By email
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis **TBD**		Primary Diagnosis Code TBD

Patient Secondary Diagnosis	Secondary Diagnosis Code
TBD	TBD

If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled	
Date of Good Faith Estimate: _____ **Summary of Expected Charges** (See the itemized estimate attached for more detail.)	
Provider Name Dr. Jane Jenkins	Estimated Total Cost $7,200 (40 weeks plus Dx session)
Provider Name	Estimated Total Cost TBD
Provider Name	Estimated Total Cost TBD
Total Estimated Cost: $ (See below)	

The following is a detailed list of expected charges for psychotherapy or other service, scheduled for_____. "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

Estimate

Provider/Facility Name		Provider/Facility Type
Dr. Jane Jenkins/Root to Rise Psychological Services, PLLC		Psychological Services
Street Address		
330 North Grand Avenue, Suite 330		
City	State	ZIP Code
Pullman	WA	99163
Contact Person	Phone	Email
Jane Jenkins	(754) 227-9480	DrJane@rtrpsych.com
National Provider Identifier		Taxpayer Identification Number
1083027486		88-1480636

Details of Services and Items for Dr. Jane Jenkins, Root to Rise Psychological Services, PLLC

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Initial Diagnostic Evaluation	Via Telemental Health OR 330 N. Grand Ave, Pullman, WA	TBD TBD	90791 90834 90837	Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns.	This Good Faith Estimate explains your therapist's rate for each service provided. Please note the expected cost is based on the fee times the number of sessions needed as determined in collaboration with your therapist.

Total Expected Charges from Root to Rise Psychological Services, PLLC: $ TBD as stated above
Additional Health Care Provider/Facility Notes Costs estimated for 40 weeks of sessions. Actual necessity TBD as therapy progresses.

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 careprovider 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 Dr. Jane Jenkins at (754) 227-9480.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

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

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$200
	90832	Psychotherapy, 16-37 minutes	$140
	90834	Psychotherapy, 38-52 minutes	$175
	90837	Psychotherapy, 53-60 minutes	$175
	90839	Psychotherapy for a Crisis (30-74 minutes)	$175
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$90
	90846	Family Psychotherapy without Patient Present, 50 minutes	$175
	90847	Family Psychotherapy with Patient Present, 50 minutes	$175
	90853	Group Psychotherapy	N/A
	96130-96133, 96136-96139	Psychological and Neuropsychological Testing	N/A
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for $50 per occurrence
	Production of Records		$175
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you any questions or concerns have been addressed. Thank you!

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date of signature