 New Perceptions, Inc. P.O. Box 5360 Augusta, Maine 04332 Tel. 207-941-0010 or 603-257-0258 Fax (888)-977-1570	**Treating Provider Name:** **License/#:** **Provider NPI # (if applicable)** **Provider Tax ID# (if applicable)**

Good Faith Estimate of Services

Patient Name:	Patient Date of Birth:
Patient Address (include if telehealth):	
Patient Diagnosis (if known/applicable):	
Services Requested:	Date of Initial Session (if applicable):

You are entitled to receive this "Good Faith Estimate" of what the charges could be for the services New Perceptions provides to you. While it is not possible for New Perceptions to know, in advance, how many therapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of therapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

The fee for a 50-minute therapy visit (in-person or via telehealth) with Provider Amy Davenport-Dakin, LCMHC, LCPC is $200. The fee to attend a 50-minute therapy visit (in-person or via telehealth) with a student intern at New Perceptions is $25.00.

Most clients will attend one therapy visit per week, but the frequency of therapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of $200 per visit, if you attend one therapy visit per week, your estimated charge would be $800 for four visits provided over the course of one month; $1,600 for eight visits over two months; or $2,400 for 12 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Should you receive services from a student intern of New Perceptions, based upon a fee of $25 per visit, if you attend one therapy visit per week, your estimated charge would be $100 for four visits provided over the course of one month; $200 for eight visits over two months; or $300 for 12 visits

over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

DISCLAIMER

There may be additional items or services your New Perceptions provider may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

If you are billed for $400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill. You may contact Amy Davenport-Dakin at the contact listed above to let New Perceptions know the billed charges are at least $400 higher than this Good Faith Estimate. You may ask New Perceptions to update the bill to match this Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You also have the right to initiate a dispute resolution by contacting the U.S. Department of Health and Human Services (HHS). To learn more about your rights for a Good Faith Estimate or to get a form to initiate the dispute resolution process through HHS, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of therapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

By signing below, you acknowledge that:

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents including my right to receive a Good Faith Estimate.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient's Signature____ Date______________________

OR

Authorized Representative's Name____

Authority under State Law (e.g., guardian, health care power of attorney)_______________________

Signature____ Date______________________