DREW'S PLACE PSYCHOTHERAPY SERVICES, INC.

1388 COURT ST, SUITE A-1, REDDING, CA. 96001 / 530-338-1452

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Good Faith Estimate for Healthcare Services 2023

Date of Good Faith Estimate: _____

Client Name: _____ Date of Birth: _____

Phone Number: _____ Client Email: _____

Address: _____

Service Requested/ Scheduled: _____

Client Primary Diagnosis (w/ code): _____

Client Secondary Diagnosis (w/ code): _____

If scheduled, list the date the primary service or item will be provided: _____

Billed Prices for Services Rendered

Code	Description	Length	Billed Amount
90791	Psychological Diagnostic Evaluation	50 Mins	$150
90837	Psychotherapy, 60 mins	50 Mins	$150
90834	Psychotherapy, 45 mins	45 Mins	$130
90832	Psychotherapy, 30 Mins	30 Mins	$80
90838	Psychotherapy, Add-on, 60 mins	50 Mins	$150
90847	Family Psychotherapy, with patient present	50 Mins	$150
90853	Group Therapy	50 Mins	$150
LCX	Late Cancel	-	$75
NS	No Show/ 2 hour CX****	-	$150

Group Practice Information:

Group NPI: 1073272928

Group Tax ID: 87-3781777

Individual Provider Information:

____ Staci Bertagna, MSW, LCSW

Individual NPI: 1689098147

Individual Tax ID: 20-8993851

____ Robert Francis, PsyD

Individual NPI: 1639402241

Disclaimer: The Good Faith Estimate shows the cost of items and services that are reasonably expected for your healthcare 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 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 how 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 [HHS PHONE NUMBER]. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____