Good Faith Estimate for Health Care Items and Services

Client Information
Client Name:
Date of Birth:
Address:
Phone Number: Email:

Provider:
Address:
Phone: Email:
Provider License(s):
NPI Number: TIN:
Location of Services:
or Client's address if services provided via TeleMental Health.

Diagnosis (if known/applicable):
Providers may have diagnoses for existing clients; however, prospective or new clients may not yet have a diagnosis. If information is not available, the provider will make a reasonable attempt to include expected service codes and expected charges associated with the service(s).

Primary Service Requested:
Ancillary Services, if any:

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy 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 psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This Good Faith 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.

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 psychotherapy 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.

The fee for a 50-minute psychotherapy session (in person or via telehealth) is $
Most clients will attend one psychotherapy session per week, but the frequency of psycho-

therapy sessions that are appropriate in your case may be more or less than once per week, depending upon your needs. Based on the per-session fee stated above, the following are estimated costs of psychotherapy services:

Number of Weeks	Total estimated charges if attending 1 session/week
13 Weeks of Service (approx. 3 months)	$ 0.00
26 Weeks of Service (approx.. 6 months)	$ 0.00
39 Weeks of Service (approx.. 9 months)	$ 0.00
52 Weeks of Service (approx.. 12 months)	$ 0.00

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more above the estimated charges). 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.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). Choosing to initiate the dispute resolution process will not adversely affect the quality of the psychotherapy services you receive from your provider. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about four months) of the date on the original bill. HHS charges 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 provider(s), you will be required to pay the amounts billed. To learn more, get a form to start the process, or for any other questions about your rights, go to www.cms.gov/nosurprises, or call HHS at 800-368-1019.

Please 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.

Estimate Dated:

Provider

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