Good Faith Estimate for Health Care Items and Services for Self-pay and out-of-network services

Patient			
Patient Full Name:		Date of Birth:____/___/_____	
Street or PO Box			
City	State Zip Code		
Phone			
Primary Diagnosis (if applicable) _____ Diagnosis code: _____			
Secondary Diagnosis (if applicable) _____ Diagnosis code: _____			
Service Type	Description	Service Code	Estimated amount to be billed*
Individual	Initial Diagnostic Evaluation (Intake Session) 60 min	90791	$175.00/Session
Individual	Psychotherapy, 50 min-60 min	90837	$167.00/Session
Family	Family psychotherapy, psychotherapy with the patient present		
	Missed or cancelled appointment within 24 hours of scheduled appointment		$75.00/Session
Non-clinical and administrative task	For example: additional summaries (one provided every three months at no cost), extended phone calls, professional appearance (i.e. court and other legal obligation on behalf of the client), professional letter etc.		$40.00 per 15 minute
The estimated costs are valid for 12 months from the date of the Good Faith Estimate. This estimate is based on one 50-60 min session a week for 50 weeks.			
Total estimate of what you may owe/billed per session*			
Provider signature:		Date:	
NPI (if applicable)			

Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted 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, including extended session, additional sessions, interactive complexity, administrative charges (legal proceeding, administrative documentation requests, etc.). 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

Provider Signature: _____
Date _____

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.