Clinician
Name of Practice
Practice Address
Phone number
email address
website (if applicable)
Federal Tax ID:
NPI

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## Good Faith Estimate for Health Care Items and Services

Date:

Patient Name:
Patient Date of Birth:
Patient Identification Number (if applicable):

Address:
City:
State:
Zip Code:
Phone:
Email Address:
Patient's preferred Contact Preference for written communication: [ ] Email [ ] Postal Mail

Responsible Party (if not the patient):

Do you have health insurance of any kind: [ ] Yes [ ] No
Insurance Company:

If you do not have health insurance, please initial that you understand you are directly responsible for all fees for services provided to you: _____

If you have health insurance, please initial whether or not you will choose to use your insurance or to pay for your services on a fee-for-services basis:
[ ] I will use my health insurance out-of-network benefits. I acknowledge that I will be responsible for paying all fees to this practice at the time of service or upon receipt of invoice and for submitting a superbill directly to my insurance company for my out-of-network benefits. _______
[ ] I decline to use my health insurance out-of-network benefits and will pay in full for all services at the time of service or upon receipt of invoice. _______

Unlike some medical services, with behavioral health services your clinician often cannot form an estimate of what services you will need and what they will cost until the clinician has evaluated you. Even then, the extent of the services you will need will be influenced by many factors. Your clinician will review your treatment plan and services needs with you throughout your treatment with us that may not be reflected in this estimate.

We are providing you with this good faith estimate based on the information the clinician has available at this time and actual items, services, or charges may differ from this good faith estimate as treatment progresses. Here is a chart of typical fees for services the practice provides that will be in effect for January 1, 2022 through December 31, 2022. Please note that these fees are the same for both in-office services and for telehealth services.

| **Date of service and/or estimated frequency** | **Service code (CPT Code)** | **Description** | **Fee for Service** |
|---|---|---|---|
| | 90791 | Initial Diagnostic Evaluation | [Insert fee for this code] |
| | 90832 | Psychotherapy, 16-37 minutes | [Insert fee for this code] |
| | 90834 | Psychotherapy, 38-52 minutes | [Insert fee for this code] |
| | 90837 | Psychotherapy ≥ 53-60 minutes as well as my hourly rate | [Insert fee for this code] |
| | 90839 | Psychotherapy for a Crisis (30-74 minutes) | [Insert fee for this code] |
| | +90840 | Psychotherapy for a Crisis (add on code for each additional 30 mins) | [Insert fee for this code] |
| | 90846 | Family Psychotherapy without Patient Present, 50 minutes | [Insert fee for this code] |
| | 90847 | Family Psychotherapy with Patient Present, 50 minutes | [Insert fee for this code] |
| | 90853 | Group Psychotherapy | [Insert fee for this code] |
| | 96130-96131 | Psychological Testing | [Insert your fees and # of units by code] |
| | 96132-96133 | Neuropsychological Testing | [Insert your fees and # of units by code] |
| | 96136-96137 | Testing Administration by Psychologist | [Insert your fees and # of units by code] |
| | 96138-96139 | Testing Administration by Technician | [Insert your fees and # of units by code] |
| | Cancellation Fee | [Customize such as "Your Therapist Requires a 24-Hour Cancellation Fee"] | [Customize such as "Total cost of the service code scheduled" or $XX] |
| | Records | Describe services to be provided, for example copying and mailing records | [Insert your fees] |
| | Forensic and/or legal fees | Describe services to be provided | [Insert your fees] |
| | Consultation Fees | Describe, such as phone calls, school meetings, other services not covered by health insurance plans | [Insert your fees] |

You are seeking an [ ] Evaluation [ ] Treatment [ ] Other Service________________________________

Diagnosis is
[ ] prospective [ ] based on information provided by the patient [ ] based on the clinician's evaluation
[ ] only for the person who services will be billed under, who is ________________________________

Primary Diagnosis: ____________________________________________________________________
[ ] To Be Determined – a diagnosis cannot be made until your evaluation is completed
[ ] Z63.0 Problems in relationship to spouse or partner
[ ] Z65.9 Problem related to unspecified psychosocial circumstances

Secondary Diagnosis (if applicable): _______________________________________________________

[ ] Scheduled date services will be provided:
[ ] Primary Services not yet scheduled

We have calculated your charges as follows: [if you are providing therapy and do not know many sessions are anticipated, and therefore prefer not to do a yearly calculation, one suggestion is to say "Based on the information you have provided to date, our best estimate is we will be providing one service with code 90791 for the first session and subsequent sessions we will be providing services with code 90847 with the above rates. Together throughout treatment we will discuss how many sessions and the types of services that will be of the most benefit to you based on your diagnosis, your presenting concerns, and other relevant information that presents as we continue treatment together.]

[Narrative of the calculation if there is a typical amount of therapy sessions, e.g. we anticipate to meet biweekly, therefore our best estimate for the total charge you will incur is $________, calculated as 26 sessions x $XXX equals $XXXX for the year]

This estimate is for services provided in the coming year. Your clinician will provide you an updated estimate when your clinician determines it is relevant to do so. Your clinician will provide you a new estimate one year from now if you are continuing to participate in services here. You are welcome to ask questions about your services, their costs and this estimate.

By signing this document, I understand that this is not a contract. I also understand that if I have insurance, by signing this document it indicates I have decided to utilize out-of-network services rather than utilize in-network services that may be less expensive. I also understand it is my responsibility to send a superbill to my insurance carrier if I want to use any out-of-network benefits that may be included in my insurance plan.

Signed:

_____________________________________________________ _________________________
Patient Date

___________________________________________________ ________________________

Responsible Party (if not Patient) Date

___________________________________________________

Please print name of Responsible Party

## 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 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 800- 985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059.

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.