Good Faith Estimate

Date of Good Faith Estimate:

This estimate is for psychotherapy services through

The estimate below is the range of costs/costs that is likely for most new patients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues, and ~~needs. I typically see therapy pati~~ents for 52 sessions for a total cost of $80. But in some cases a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

The estimate below is the range of costs/cost that I think are likely for your care over the time period covered by this estimate. However, depending on how the treatment progresses, more or fewer sessions may be needed.
Contact: If you have questions about this estimate, please contact Austin Pohevitz at austinpoh@pushingboundariesmh.com
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Details of the Estimate
The following is a detailed list of expected charges for psychological services scheduled for [date or dates]. [Include the following for reoccurring services like psychotherapy.] The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless [I/we] send you an updated Estimate.

Service	Diagnosis Code(once determined)	Service code	Quantity (# of sessions or units. Give number or range)	Cost per unit	Expected cost
Initial evaluation	[use ICD codes]	90791		$	$
Psychotherapy		90837 and/or 90834			

Total estimated cost: $____[number or range]_____
Psychologist providing services: Name _____ [you can delete this if you are a solo practitioner or the practice name is the same as the treating psychologist]
NPI number: _____ TIN: _____
Address of office from which services will be provided _____ [This is only needed if you have multiple offices and you'll be providing services from a different office than the one listed at the top of the notice]

Name

Date

Good Faith Estimate

Patient information:
Patient name _____ DOB _____

Disclaimer
This ~~Good Faith Estimate shows the~~ costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to [us/me] when [we/I] did the estimate.
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.

I**f 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 the chapter & Page Counseling LLC at the contact listed above to let them know the billed charges are at least $400 higher than the GFE. You can ask them to update the bill to match the GFE, 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 GFE. 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 CMS at 1-800-985-3059.
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059 .

This GFE is not a contract. It does not obligate you to accept the services listed above.

Keep a copy of this Good Faith Estimate (GFE) in a safe place or take pictures of it. You may need it if you are billed more than $400 than the estimate provided above.

Name _____ Date _____