Good Faith Estimate

(Insert your provider's name here), 2201 Ridgewood Rd., Suite 400, Wyomissing, PA 19610
Date of Good Faith Estimate: ___/____/___ This estimate is for psychotherapy services through _____.

Brief explanation for continuing patients: The estimate below is the cost that I think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact (Insert your provider's name here) at 610-378-9601.

Details of the Estimate

The following is a detailed list of expected charges for services scheduled _____. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I 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 w/o meds		90791		$	$
Psychotherapy		90837 and/or 90834		$	$
Initial evaluation w/meds		90792		$	$
Medication Management		99211-99215		$	$

Total estimated cost: $_____

Clinician providing services: Name (Insert your provider's name here)

NPI number: (Insert your provider's NPI here)

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 me when 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.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the provider at the contact listed above 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 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 Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than $400 than the estimate provided above.