Good Faith Estimate

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For services from _____ to _____

Please keep a copy and return a copy to the therapist.

Client

Name _____ Date of birth _____

Address _____

Phone _____ Email _____

Diagnosis _____

What this document is

This is a Good Faith Estimate of expected charges for services to be rendered, in accordance with the No Surprises Act. All services are the financial responsibility of the client. **This is not a bill.**

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage, both orally and in writing, upon request or at the time of scheduling health care items and services.

Services and fees

Service	Code	Length	Place of service	Fee
Individual psychotherapy	90834	50 minutes	Telehealth (02 / 10), Texas	$240
Trail walk and movement therapy	90834	1 hour	In person, central Texas	$125
Equine-assisted therapy	90834	1.5 to 2 hours	In person, Dripping Springs	$185 to $240

Blue Cross Blue Shield PPO is billed through insurance. Sessions under any other plan are self-pay. Trail walk and equine sessions are private pay only and are not billed to insurance; both are paid in advance.

Estimate for the year

At the individual psychotherapy rate of $240 per 50-minute session:

52 weekly sessions = **$12,480** 26 fortnightly sessions = **$6,240**

Your therapy needs may vary throughout the year. You may need less or more frequent sessions, which would change this estimate accordingly, and you may discontinue therapy at any time. This estimate is valid for 12 months from its date. It is not a contract; it is an estimate of your treatment costs for the next year if you attend weekly sessions, not counting holidays, breaks or early termination. Additional charges may apply for extra sessions, report or letter writing, and missed appointments, all charged at the fee for service per therapeutic hour.

Your right to dispute 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 named above to tell them the billed charges are higher than this estimate, ask for the bill to be updated to match it, ask to negotiate, or ask whether financial assistance is available.

You may also start a patient-provider dispute resolution process with the U.S. Department of Health and Human Services. If you choose to do so, you must start it within 120 calendar days of the date on the original bill. An administrative fee applies; the current amount is listed at cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit **cms.gov/nosurprises** or call **1-800-985-3059**.

Client signature _____ Date _____

Therapist signature _____ Date _____