No Surprise Act: Good Faith Estimate Notice

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, healthcare providers must give patients who don't have insurance or are not using insurance an estimate of the bill for medical items and services.

The following is a detailed list of expected charges for psychological services. [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. 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.

If you have questions about this estimate, please contact Benita Weems at 407-616-9027 & admin@holdinghopetherapy.org

Date of Good Faith Estimate: ____/____/_____. This estimate is for psychotherapy service through ___/____/_____.

Service	Diagnosis Code	Service Code	Number of sessions	Session Fee	Expected Cost
					$0.00
					$0.00
					$0.00
Notes:				Subtotal	$0.00

Total Estimate Cost: _____

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.

If 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 Benita Weems 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 (DHHS). 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.

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.

Signature of patient or legally authorized individual	Patient's Date of Birth
Printed Name (and relationship if signed on behalf of the patient)	Date
Benita Weems, M.A.; MDIV; M.A. LMHC	Date