GOOD FAITH ESTIMATE OF HEALTH CARE ITEMS AND SERVICES

ALL SERVICES WILL BE PROVIDED BY counselor name

*DATE OF GOOD FAITH ESTIMATE:*_____

*Date(s) of scheduled appointment(s):*_____

*CLIENT NAME:*_____ *CLIENT DATE OF BIRTH:*_____

*CLIENT MAILING ADDRESS:*_____

_____

*CLIENT PHONE #:*_____ *CLIENT EMAIL:*_____

*CT PRIMARY DIAGNOSIS & CODE:*_____
*CT SECONDARY DIAGNOSIS & CODE:*_____
*CT TERTIARY DIAGNOSIS & CODE:*_____

Please note that your diagnosis could change during the course of treatment but does not impact this GFE

SERVICE(S) TO BE SCHEDULED AND COST OF SERVICE:

90791 (INTAKE ASSESSMENT)	usually billed once upon intake
90837 (53+ MINUTE SESSION)	most frequently used
90834 (38-52 MINUTE SESSION)	
90832 (16-37 MINUTE SESSION)	
90847 (FAMILY THERAPY W/ CT PRESENT)	used upon client request
90846 (FAMILY THERAPY W/O CT PRESENT)	used upon client request

*ESTIMATED NUMBER OF SESSIONS:*_____*(CIRCLE FREQUENCY BELOW)*

WEEKLY BIWEEKLY MONTHLY INTERMITTENTLY AS REQUESTED BY CT

ESTIMATED COST OF SERVICES USING 1 INTAKE AND ALL 90837:_____

This estimate is good for 12 months from the date identified above

PROVIDER NAME: *PROVIDER NPI #*

PROVIDER PHONE #: 563-556-0699 *PROVIDER LICENSE #:*

PROVIDER EMAIL:
PROVIDER FACILITY ADDRESS: 300 Main St. Suite 230 Dubuque, IA 52001

DISCLAIMER

This Good Faith Estimate (GFE) shows the costs of services that are reasonably expected for your health care needs. 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. Refer to the Informed Consent document for potential 'out-of-session' costs including a $50 no show/late cancel fee, phone calls lasting longer than 15 minutes, and any court-related services. These 'out of session' costs cannot be pre-determined and are therefore not included in this GFE. You are responsible for charges related to special circumstances that may change the above-identified estimate. Federal law regarding the "No Surprises Act" allows you to dispute the bill if it is different than the above-identified estimate. You may contact the health care provider and/or facility listed above to let them know that the billed charges are higher than the GFE. You have the following rights: (1) ask them to amend the charges to match the GFE; (2) ask to negotiate the bill and/or ask if financial assistance is available; (3) dispute the resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to dispute the billed charges, you must begin your dispute within 120 calendar days 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 be responsible for the amount listed on this GFE. If the reviewing agency disagrees with you and upholds the bill administered by your health care provider and/or facility, you will be responsible for the billed amount, even if it is higher than the estimated costs on the original GFE. To learn more and/or obtain a form to begin the appeal process, go to www.cms.gov/nosurprises or call HHS.

I UNDERSTAND AND AGREE TO THIS GOOD FAITH ESTIMATE:

*CLIENT SIGNATURE:*_____ *DATE SIGNED:* _____

*PROVIDER SIGNATURE:*_____ *DATE SIGNED:* _____