

Good Faith Estimate for Health Care Services

Provided in compliance with the No Surprises Act

What Is a Good Faith Estimate?

As required by the No Surprises Act, this document provides a **Good Faith Estimate (GFE)** of expected costs for mental health services. This estimate outlines the anticipated charges for services you may receive at my practice. The goal is to help you make informed financial decisions regarding your care.

The Good Faith Estimate applies to individuals who:

- Do not have health insurance
- Are not planning to submit claims to their health insurance provider
- Are receiving services from an out-of-network provider

Services and Fees

The following is a detailed list of the services I offer and their associated fees. This estimate is based on your specific treatment plan and anticipated frequency of sessions.

Service	CPT Code	Rate Per Session	Estimated Frequency	Estimated Total
Initial Intake Assessment	90791	\$160	1 Session	\$160
Individual Therapy Session (60 min)	90837	\$135	TBD	\$135/session
Letter writing (FMLA, disability paperwork, ESA, gender affirming care surgery)	99080	\$30	As requested	\$30/15 min

Total Estimated Cost: The healing process in therapy is highly individualized, as it depends on many factors unique to each person. Because of this, the exact estimate, total cost or duration of your treatment is not able to be identified. The length of therapy varies based on factors such as:

- The nature and complexity of the concerns being addressed
- Your personal goals for therapy
- Your progress over time
- External circumstances that may impact your journey

While the **Good Faith Estimate** includes an approximation of costs based on an initial understanding of your needs, please note that it does not guarantee a specific number of sessions or an exact timeline for healing. Therapy is a collaborative and evolving process, and adjustments to your treatment plan may be made as we progress.

I am committed to discussing your treatment plan openly and will provide updates to the estimate if there are significant changes in the anticipated duration or scope of care. Together, we'll work to ensure that therapy aligns with your goals and that you feel supported throughout the process.

Important Notes About This Estimate

- The actual frequency and duration of services may vary depending on your specific needs, progress in therapy, and treatment goals.
 - This estimate is valid for 12 months from the date it is provided.
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Your Rights

You have the right to:

1. Receive a Good Faith Estimate of expected charges before your scheduled services.
2. Dispute a bill that is significantly higher than the estimate provided (exceeding \$400 more than the GFE).
3. Request updates to your Good Faith Estimate if your treatment plan or services change.

For more information about your rights under the No Surprises Act, visit [No Surprises: Understand your rights against surprise medical bills | CMS](#).

What If My Costs Exceed This Estimate?

If the actual costs of your treatment exceed this estimate by \$400 or more, you have the right to dispute the charges. To dispute, you must file a claim with the U.S. Department of Health and Human Services (HHS) at [Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution \(PPDR\) Process for People without Insurance or Who Plan to Pay for the Costs Themselves | Guidance Portal Search Results for good faith estimate | HHS.gov](#).

Acknowledgment

By signing below, you acknowledge that you have received and reviewed this Good Faith Estimate.

Patient Signature: to be signed electronically through client portal.