**Good Faith Estimate for Health Care Items and Services**

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual needs and circumstances, and the type and amount of services that are provided to you.

This estimate is NOT a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. There is no change to cost of services and we as therapists determine our costs based on government regulations, this is just a formalized way to notify all patients what their estimated costs of therapy are.

**Disclaimer**

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what we agree to in consultation. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

This 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.

**Please complete the following:**

**Full Name:**

**Date Of Birth:**

**Diagnostic Code**

Good Faith Estimate

This Good Faith Estimate provided by:

NPI: 1386279560 TIN: 84-4704442

Services will be provided via telehealth or in-person at Infinity Wellness Center & Consulting

I anticipate your treatment will include a variety of the following billing codes.

Diagnostic evaluation (90791

60 Minute therapy appointment (90843)

45 Minute therapy appointment (90834

30 Minute therapy appointment (90832 )

 Most clients will attend one psychotherapy visit per week or one psychotherapy visit per 2 weeks, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

Example: Total estimated charges for 1 session per 2 weeks including the initial Diagnostic Evaluation::

4 Weeks of Service (Approx. 1 Month including 1 x 90791@ $170 and 1 x 90834 @ $150) $ 320

12 Weeks of Service (Approx. 3 Months; including 1 x 90791 @$170 and 1 x 90834 @ $150) $ 926

There may be additional items or services recommended as part of the course of treatment that would be scheduled or requested separately and are not reflected in this good faith estimate. These additional services may include

Family Psychotherapy (90847

Psychotherapy for Crisis (90839)

No Show or Late Cancelation Fee $100

There are non-medical costs that are not included on this GFE that do not apply to all patients and will be provided if or when those services are needed. These services may include court fees, school meetings, disability forms or other consultation outside of the normal therapeutic services.

**Dispute Process**

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact if your billed charges are higher than the Good Faith Estimate. You can ask to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. You may 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.

For questions or more information about your right to a Good Faith Estimate, or to start the dispute process, go to www.cms.gov/nosurprises or call (877) 696-6775.

**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 a higher amount.**