Patient name ____ DOB ___________

If a minor, Parents' name____

Contact information:
Mailing Address____

Phone_____________________ Email__________________________________

Date of Good Faith Estimate: 9/11/2023

This estimate is valid for **12 months from the date of estimate** unless revisions are made with your clinician.

Brief explanation of estimate for new patients:
Under the "No Surprise Act", health care providers need to give patients who don't have insurance or who are not using insurance (including submitting for "out of network" reimbursement) an estimate of the bill for medical/psychological services.

The estimate below is the range of costs that is likely for most new patients. Until we do an initial evaluation and we start to work together, we will not have a clear picture of your specific diagnosis, issues and needs.

The initial evaluation to determine diagnosis and treatment plan is billed at $300 for a 60-minute intake.
The CPT Code for this service is 90791 and Diagnosis Code is **TBD** until further notice**.**

We typically see therapy patients for multiple sessions at the rate of $250 per individual session or $100 per group therapy session. But in some cases, a patient's problems may be more complicated, so we may need additional sessions during the time covered by this estimate.

The CPT/Procedure Codes we typically use are:
- 90834 (45 Minute Individual Therapy)
- 90853 (Group Therapy)
- 90832 (30 Minute Individual Therapy)
- 90847 (Family Therapy with Client Present)
- 90846 (family Therapy without Client Present)

The estimate below is the range of costs that your clinician estimates is likely for your care over the time period covered by this estimate beginning on this date 2/6/2023 and ending 12 months later, unless we send you an updated estimate. However, depending on how treatment progresses, more or fewer sessions may be needed and it may be revised as necessary.

It is important to understand that this fee is not expected to be paid all at once, it is an estimate of cost that you can expect to pay (or submit to insurance) over the course of treatment.

Details of the Good Faith Estimate
The following is the expected charges for psychological services based on the information known to [us/me] when [we/I] did the estimate:

$250/45 Minute Individual or Family Session PER Session

Providers providing services:

Dina Cagliostro, Ph.D.
National Provider Identifier (NPI): 1396039210
Taxpayer Identification Number (TIN): 27-1616368

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 more than this Good Faith Estimate, you have the right to dispute the bill.
You may contact the [provider/practice] at the contact listed above to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, 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 (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.

To learn more and get a form to start the process, go to: www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

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 Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than $400 than the estimate provided above.

Patient Signature____ Date _______________