Harmony Counseling, LLC
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GOOD FAITH ESTIMATE FOR OUT OF POCKET EXPENSES

OMB Control Number 0938-XXXX
Expiration Date: 12/31/2022

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

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescriptions drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate.

For questions, more information about your right to a Good Faith Estimate, or to submit a complaint about your medical billing, visit www.cms.gov/nosurprises or call the No Surprises Help Desk at 1-800-985-3059.

DISCLAIMER

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. 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 additional services are needed/requested according to your treatment plan. If this happens, federal law allows you to dispute (appeal) the bill. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) from the date on the original bill.

This Good Faith Estimate is not a contract and does not require the client to obtain the items or services from any of the providers or facilities identified in this document.

Client Name: _____

Client Date of Birth: _____

Client Mailing Address: _____

Client Phone Number: _____

Client Email Address: _____

Client Service(s) or Item(s) Requested/Scheduled:

_____

Client Primary Diagnosis and Code:

_____

Client Secondary Diagnosis and Code:

_____

Provider Name: Trisha R. Hobson, MA, LPC

Provider National Provider Identifier (NPI): 1841324597

Provider Taxpayer Identification Number (TIN): 84-4555982

Estimated Services and Items to be Provided:

1. Individual Psychotherapy, 60 minutes - CPT Code 90837

   Estimated Cost Per Session: _____

2. Family Psychotherapy, conjoint with patient present - CPT Code 90847

   Estimated Cost Per Session: _____

3. Family Psychotherapy without Patient Present - CPT Code 90846

   Estimated Cost Per Session: _____

Total Estimated Cost: Depending on the progress we make this year, recurring weekly sessions at an estimated rate of _____ per session for an estimated 50 weeks per year, accounting for vacations and holidays, would equal a total estimated cost of _____.

Date of Good Faith Estimate: _____