"NO SURPRISES ACT" GOOD FAITH ESTIMATE

Provider Information

Name: Patricia Moore

NPI: 1669127221

Address: PO Box 250, Arcadia, OK 73007

Tax ID: N/A

Phone: 405-229-8823

License: N/A under supervision

Patient Information

Name: _____Date of Birth: _____

Address:_____

Phone:_____Email:_____

Primary Diagnosis and Diagnosis Code:	
Services Requested:	Date of Initial Session (if applicable):

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 your therapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person(s), 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 circumstances, and the type and amount of services that are provided to you. 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.

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.

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. There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). You may contact the health care provider or facility listed 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.

For questions or more information about your right to a Good Faith Estimate or the dispute resolution process, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

I anticipate your treatment will require weekly 45-50-minute psychotherapy sessions throughout the next 12 months at [$80.00] per session for a total of 50 weeks taking into consideration availability for an estimated total of [$80.00] x [50]. Based upon a fee of $80.00 per visit, if you attend one (psychotherapy) session per week, your estimated charge would be $4,000.00.

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 you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Client Signature:

_____Date:_____

Client Signature:

_____Date:_____

Therapist Signature:

_____Date:_____