



Therapeutic Time, Inc.

Good Faith Estimate

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Marriage & Family Therapist MFC 42603, & National Certified Counselor NCC 264935

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For Cash-Only Clients

Pursuant to the No Surprises Act (HR133, Title 45 Section 149.610), this form is used to provide a current or prospective client with a "Good Faith Estimate" (GFE) of expected charges for services to be provided. This template is a hybrid of those recommended by several therapist professional associations.

Client Name:	Date of Birth:
Services Requested (Type and 60 min CPT Codes): Check One <input type="checkbox"/> Individual Outpatient Counseling (90837) <input type="checkbox"/> Family Outpatient Counseling (90847) <input type="checkbox"/> Couples Outpatient Counseling (90847) <input type="checkbox"/> Group Outpatient Counseling (90853)	

Please select your Provider: Therapeutic Time Inc. Psychologist: <input type="checkbox"/> Dr. Trisha Rich-Thurm Psychological Associate: <input type="checkbox"/> Liliana Chavez Weichold, MA, Psychological Associate <input type="checkbox"/> Sarah Barajas, MA, Psychological Associate	License #: Licensed as a Clinical Psychologist PSY 24976 Marriage & Family Therapist MFC 42603 National Certified Counselor NCC 264935 PA# PBS 94027514 PA# PSB 94027905
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You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While a psychotherapist can't 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 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 that may be recommended during treatment to you that are not identified here. 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.

This section will be completed with your therapist once the frequency and type of session are determined:

The fee for a 50-minute Psychologist visit and a 45-minute Psychological Associate visit (in person or via telehealth) is \$_____. Most clients will attend one psychotherapy visit per week, 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. Total estimated charges per session (based on need determined by the therapist with the client's input) per visit fee cited above, the following are expected charges for ___ times per month would be \$_____.

You have a right to dispute a bill 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). Initiating the dispute process will not adversely affect the quality of services rendered to you. 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, 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 HHS at (800) 368-1019. 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.

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

Date of this Estimate: _____ Psychologist or Psychological Associate Initial's: _____

Your signature below indicates that you have read the information in this document and agree to its terms.

In the case of treating a minor: **Sign Below:**

Signature of Client

Date

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date