**SAMPLE GOOD FAITH ESTIMATE**

The No Surprises Act, which was signed into law on December 27, 2020, amends the Public Health Service (PHS) Act by establishing requirements for health care providers and facilities to protect patients from surprise medical bills and to provide good faith estimates (GFE) to potential patients. On September 30, 2021, the Departments of Health and Human Services, Labor, and Treasury issued an interim final rule with comment period outlining the details of the GFE and other provisions of the statute.

**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 are entitled to receive this “Good Faith Estimate” of what the charges could be for **[INSERT YOUR THERAPY SERVICES]** provided to you. While it is not possible for us to know, in advance, how many 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 sessions you attend, your individual 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.

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 therapy 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 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, prescription 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 or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059

|  |  |
| --- | --- |
| Provider Name | License/#: |
| Provider Address: | |
| Provider Phone #: ( ) | |
| Provider Tax ID# (if applicable): | Provider NPI # (if applicable): |

|  |  |
| --- | --- |
| Patient Name: | |
| Patient Address: | |
| Patient Phone #: ( ) | Patient Email: |
| Patient Diagnosis (if known/applicable): | |
| Services Requested: | |

The fee for a **XX-minute [INSERT YOUR THERAPY SERVICES] visit** (in person or via telehealth) is $\_\_\_\_\_\_\_. Most clients will attend two therapy sessions per week, but the frequency of visits that are appropriate in your case may be more or less than twice per week, depending upon your needs. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment. Based on a fee of $\_\_\_\_\_\_\_per visit, the following are expected charges of **[INSERT YOUR THERAPY SERVICES]** services:

|  |  |
| --- | --- |
| Number of Weeks | Total estimated charges for 2 session per week |
| 1 Week of Service | $ XX |
| 13 Weeks of Service (Approx. 3 Months) | $ XX |
| 26 Weeks of Service (Approx. 6 months) | $ XX |
| 39 Weeks of Service (Approx. 9 months) | $ XX |
| 52 Weeks of Service (Approx. 12 Months) | $ XX |

You have a 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 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.

Date of this Estimate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_