Trauma & Wellness
COUNSELING CENTER

GOOD FAITH ESTIMATE FOR HEALTHCARE COSTS AND SERVICES

Patient Name:
Communication Preference: ☐ Electronic ☐ Mail

Date of Birth:
Date of Estimate:

"Good faith Estimate" (GFE) of expected changes for services provided pursuant to the No Surprises Act. This federal act was instituted to avoid balance billing and surprise billing to recipients of healthcare services using out of network or self-pay medical services. This document is a required effort to be in compliance with such regulations.

Service Code		Service/Item	Diagnosis Code	Cost Each	Quantity	Total Cost
	90837	Individual Psychotherapy, 60 minutes		$150	4	$600
	90847	Family Psychotherapy		$150		
Total Expected Charges						**$600**

All services will be provided by:

☐ Elizabeth Lugo, LMHC, QCS. National Provider Identifier: 1578196754, Taxpayer ID Number: 87-2574960
☐ Rebecca Berndt, LMHC. National Provider Identifier: 1619722576, Taxpayer ID Number: 888-3855160

Services will be provided at:
Via telehealth
Phone: (407) 600-8855 • Contact: Elizabeth Lugo • Email: info@tawcc.com
The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer

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. 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. You could be charged more if complications or special circumstances occur. While it is not possible for a psychotherapist to 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 service will depend upon the number of psychotherapy session you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services recommended as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. 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.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. 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 have the right to initiate a disputer resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate ($400 or more beyond the estimated charges). 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. **For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Client's Name: Client signature: Date: