



# Change In Motion Therapy

## Good Faith Estimate

### Good Faith Estimate

(No Surprises Act)

**Client Full Name:**

**Client Date Of Birth:**

**Client Address:**

Services Provided::

**Client ID Number:**

Date of Initial Session:

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 a marriage and family therapist 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 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.

Required Disclaimers:

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 me, 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 or 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 me to let me know the billed charges are higher than the Good Faith Estimate. You can ask me 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 my bill, 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-minute psychotherapy sessions throughout the next 12 months at \$120 per session for a total of 48 weeks taking into consideration availability (reduced as appropriate for things like vacations, holidays, emergencies, sick time) for an estimated total of \$120 x 48. Based upon a fee of \$120 per visit, if you attend one (psychotherapy) session per week, your estimated charge would be \$480 for four visits provided over the course of one month; \$960 for eight visits over two months; or \$1440 for 12 visits over three months. If you attend (psychotherapy) for a longer period, your total estimated charges will increase according to the number of session and length of treatment.

Service Break down by Number of Weeks:

1 Week of Service

1 session per week Total estimated charges: \$120

2 sessions per week Total estimated charges: \$240

13 Weeks of Service (Approx. 3 months)

1 session per week Total estimated charges: \$1560

2 sessions per week Total estimated charges: \$3120

26 Weeks of Service (Approx. 6 months)

1 session per week Total estimated charges: \$3120

2 sessions per week Total estimated charges: \$6240

48 Weeks of Service (Approx. 9 months)

1 session per week Total estimated charges: \$5760

2 sessions per week Total estimated charges: \$11520

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 me. 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 me 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 Full Name:**

Client Signature:

Client Representative Signature:

Therapist Signature: Amelia Smith-Brown