

Good Faith Estimate; required but does not obligate you to receive any services.

** indicates a required field*

Revised 7/27/22

Expiration Date: This Good Faith Estimate expires after 15 sessions from your Intake date.

Client Information

*** Client**

First name:

Last name:

Date of birth:

*** Client Contact Information**

Street or PO box:

City, state, ZIP:

Phone number:

Email address:

Patient's contact preference:

*** Date of good faith estimate: (use the date this estimate was made available to you).**

Brief explanation of estimate for new clients:

The estimate below is the range of cost that is likely for most new clients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs. I typically see therapy clients for 8 to 15 sessions, plus an initial psychiatric evaluation, for a total cost of \$925-1625. But in some cases a client's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

Brief explanation for continuing clients: The estimate below is the range of costs that I think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact Shannon Black at 615-908-4567 or shannon@healingbravehearts.com.

Provider Estimate: \$925-\$1625 for 8 to 15 sessions plus an initial psychiatric diagnostic evaluation. Note that once 15 sessions have passed, if more services are needed, a new Good Faith Estimate will be generated.

Cost Breakdown:

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled for the date of your intake through the next 15 sessions. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I send you an updated Estimate.

Service: Psychiatric Diagnostic Evaluation

Service code: 90791

Quantity: 1

Cost per unit: \$125

Expected cost: \$125

Service: Psychotherapy

90832 16–37 minutes

90834 38–52 minutes

90837 53 or more minutes

Quantity: 8-15

Cost per unit: \$50/75/100

Expected cost: \$800-1500

Total estimated cost: \$ 925-1625

Therapist providing services: Shannon Black, LPC-MHSP-S

NPI number: 1649668567

Provider name: Shannon Black, LPC-MHSP-S, Brave Heart Counseling and Consulting
Provider/facility type: Outpatient Counseling Services
Street address: 402b Uptown Square
City: Murfreesboro
State: TN
ZIP code: 37129
Contact person: Shannon Black
Phone: 615-908-4567
Email: shannon@healingbravehearts.com
National Provider Identifier (NPI): 1649668567
Taxpayer Identification Number (TIN): N/A Utilize SS number instead.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

Throughout your treatment, the provider may recommend additional items or services as part of your treatment that are not reflected in this estimate. These would need to be scheduled separately with your consent and the understanding that any additional service costs are in addition to the Good Faith Estimate.

If your needs change during treatment, your provider should supply a new, updated Good Faith Estimate to reflect the changes to treatment, and the accompanying cost changes.

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.

The Good Faith Estimate is not a contract between provider and client and does not obligate or require the client to obtain any of the listed services from the provider.

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.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 985-3059.

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.