CENTRA PC

Comprehensive Psychotherapy & Psychiatric Associates

Good Faith Estimate for Health Care Items and Services

Patient Information:

First Name:_______________

Middle Name:_____________

Last Name:_______________

Date of Birth:_____________

Address:____

City:_____________________ State:______ Zip Code:______

Phone/Cell:____

Email Address:_______________________________________

Contact Preference: ( ) By mail ( ) By email (check the box)

Patient Diagnosis

Primary Service or Item Requested/Scheduled: (check the box)

( ) Intake Coaching ( ) Other _________________

Patient Primary Diagnosis (or temporary for new patients): ___________

Primary Diagnosis Code: ______________

Provider name: Jill Costa, ACC

If scheduled, list the date(s) the service and treatment provided

Date (s): __________ (fill in box and check service below)

( ) Check this box if this service is not yet scheduled

Service: ( )Intake ( ) Coaching Other

Date of Good Faith Estimate:_________/_________/_________

Estimated Total Cost: $125 per initial session. $155/mo with 1 session + email. $255/mo with 2 sessions + email. $355/mo with 3 sessions +email. $425/mo with 3 sessions + email + 3x 10 minute check in sessions

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Provider/Facility Name:

Street Address:

City: **State:** **Zip Code:**

Phone: **Email:**

National Provider Identifier: **Taxpayer Identification Number:** 223340716

Jill Costa, ACC (*No NPI number available for coaching)

Service/Item:
Initial or Coaching

Address where service/item will be provided:

Procedure Code:
Coaching does not have a medical CPT code

Diagnosis Code:

Quantity:
Intake session 1, Coaching sessions 1 package per month or 2 to 72 sessions per year

Expected Cost:

Additional Health Care Provider/Facility Notes:

*Frequency of coaching can be adjusted monthly. Please use a calculator for annual estimates.

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. If this happens, federal law allows you to dispute (appeal) the bill.

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 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 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

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

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.