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)
☐ Evaluation ☐ Therapy ☐ Other _____

Patient Primary Diagnosis (or temporary for new patients): Mental Health Disorder, NOS
Primary Diagnosis Code: F99

Provider name: ☐ Peggy David, LCSW ☐ Bianca Faslo, LCSW
☐ Meghan McMaster, LPC ☐ Danielle Fisher, LCSW ☐ J.R. Griffin, LCSW
☐ Caitlin Dunbar, LMFT

If scheduled, list the date(s) the service and treatment provided
☐ te (s): _____ (fill in box and check service below)
( ) Chec☐his box if th☐ervice is ☐ yet scheduled
Service: ( )Evaluation ( ) Therapy Other

Date of Good Faith Estimate:_____/_____/_____

Estimated Total Cost: Evaluation $300 per evaluation session.
$195 per therapy session.

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Provider/Facility Name:

Centra, P.C.

Street Address:

5000 Sagemore Drive Ste 205

City:	**State:**	**Zip Code:**
Marlton	NJ	08053

Phone:	**Email:**
856-983-3866	info@centrapc.com

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

☐ Peggy David, LCSW 1558488122	☐ Bianca Falso, LCSW 1841737483	☐ Meghan McMaster, LPC 1619512936
☐ Danielle Fisher, LCSW 1669496444	☐ J.R. Griffin, LCSW 1932385564	☐ Caitlin Dunbar, LMFT 1942670385

Service/Item:

Evaluation or Therapy

Address where service/item will be provided:

5000 Sagemore Drive Ste 205

Procedure Code:

Evaluation session 90791. Therapy session 90846 family therapy w/o patient or 90847 family therapy or 90834 therapy (38-52 min)

Diagnosis Code:

F99

Quantity:

Evaluation session 1, Therapy session 1 to 52 sessions per year

Expected Cost:

Evaluation $300 per session. Therapy $195 per session.

Additional Health Care Provider/Facility Notes:

*Typical frequency of therapy is 1x per week or less. Please use a calculator for annual estimate.

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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.