Psychotherapy Associates of North Reading & Amesbury, PANR.net

Good Faith Estimate (Updated 7/13/2023)

(For self pay and out of network clients only)

Date of Good Faith Estimate: ___/____/___ This estimate is for psychotherapy services for one year.

Brief explanation of estimate for new patients:

The estimate below is the estimate of cost that is likely for most new patients. 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 patients for weekly sessions for a per session cost of $_____and a yearly cost of approximately _____[e.g.*10,600.00 if seen weekly for a year*]. But in [some/many] cases a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate. An additional fee of 300.00 per hour is charged if we need to appear in court on your behalf. This fee is also charged for preparation and travel time. An additional fee of 80.00 per session if your appointment is cancelled or missed without notification at least 24 hours in advance. These fees are not billable to insurance and will be self pay.

Details of the Estimate

The following is a detailed list of expected charges for counseling services. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless [I/we] send you an updated estimate.

Fee Schedule 2023

Initial Evaluation, 90791= 200.00

Individual Therapy with patient or family member 90834, 38-52 min= 150.00

Individual Therapy with patient or family member 90837, 53-60 min=200.00

Individual Therapy with patient or family member 90832, 16-37 min=100.00

Couples or family therapy, 90847 & 90846 38-52 min=170.00

Group Therapy=80.00

Late Cancellation Fee=80.00

Court fees and related travel= 300.00 per hour door to door

Service	**Diagnosis Code** (once determined)	**Service code**	**Quantity** (# of sessions or units. Give number or range)	**Cost per unit**	**Expected cost**
Initial evaluation	TBD	90791		$	$
Psychotherapy	TBD	90837,90834 etc		$	$
Deductible					
Misc fees (court,lcf, bank charges)					

Total estimated cost: $_____

Brief explanation for continuing patients: The estimate above 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. We cannot really predict your need for court fees or cancellations or bank fees for bounced checks etc but the fees are stated above so that you can keep them in mind when making your plans for treatment costs.

Contact: If you have questions about this estimate, please contact Dr. Donna Whipple at 978-664-2566 or dwhipple@billingadvantage.com.

Therapist providing services: Name

_____

NPI number: _____ TIN: 043114833

Patient information:

Patient name _____ DOB _____

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to [us/me] when [we/I] did the estimate.

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 practice director at the contact listed above 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.

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 CMS at 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059 .

This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

*****You are choosing to be seen by a provider who is not in your insurance network or you are choosing not to use your insurance*** You may be able to obtain these services at a lower cost from a healthcare provider who participates in your plan.**

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 more than $400 than the estimate provided above.