GOOD FAITH ESTIMATE

Elizabeth Ward, Ph.D.	License #: 019254
Provider Phone #: 914.627.8199	Provider Email: drlizward@gmail.com
Provider Tax ID#: 46-3439317	Provider NPI #: 1730414764

Patient Name:	Patient Date of Birth:
Patient Address (include if telehealth):	
Patient Diagnosis (if known/applicable):	
Services Requested:	Date of Initial Session (if applicable):

As of January 1, 2022, a ruling went into effect called the "No Surprises Act" which requires that I provide my clients with a "Good Faith Estimate" explaining how much care with me will cost.

Under the law, health care providers must provide **patients who don't have insurance or who are not using insurance** an estimate of the bill for mental health and medical services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency services.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

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

Date of Good Faith Estimate: / /
This estimate is for psychotherapy services through: / /

Brief explanation of estimate for new clients:
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 psychotherapist 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.

The fee for a 45/50-minute psychotherapy visit (in-person or via telehealth) is currently $. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based upon a fee of $ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $ for four visits provided over the course of one month; $ for eight visits over two months; or $ for 12 visits over three months. If you attend

therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

There may be additional items or services that I recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. 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.

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).

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 whenever you have questions regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate or the dispute 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

Client Signature and Date
(Printed)

Client or Guardian Name and Client DOB

Witness: Elizabeth Ward, Ph.D.
(Or Printed Name of Witness)

(Signature of Witness)