West County Psychological Associates

No Surprises Act

"Good Faith Estimate" For Health Care Services

Client Name _____

Client Date of Birth: _____ / _____ / _____

Summary of Expected Charges:

Provider Name: Amy Maus, MSW, LCSW

Service: Psychoeducational evaluation

Diagnostic Code: To be determined (TBD)

Fee per hour: $180

Expected total fees: $1,600 - $2,100 per evaluation

Note: The total fee will be the number of hours of the evaluation multiplied by the hourly fee. The range of $1,600 to $2,100 is the best estimate at the outset of the process. Some clients test more quickly or slowly than others, and sometimes additional evaluation is necessary as more information becomes known. Therefore, an exact fee cannot be given in advance.

_____

Signature of client or client's parent/guardian if under age 18

Date of Good Faith Estimate (Today's Date): _____ / _____ / _____

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

- Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.
- 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.

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 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 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.

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 a picture of it.