7150 Heritage Village Plaza, Unit 201 Gainesville, VA 20155

11733 Bowman Green Drive, Suite 100 Reston, VA 20190

13356 Midlothian Turnpike, Suite 201 Midlothian, VA 23113

44075 Pipeline Plaza, Suite 300 Ashburn, VA 20147

Good Faith Estimate Form

Date of Good Faith Estimate: ___/____/___ This estimate is for psychotherapy services through [Date]

Brief explanation of estimate for new clients:

The estimate below is the range of costs 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 1x weekly sessions for a total cost of $150-$240 per session. But in some cases, a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

Brief explanation for continuing clients: The estimate below 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.

Contact: If you have questions about this estimate, please contact Alicia Ayvas, LCSW, CEDS-C at 571-318-9141 or at ClarityCounselingVA@gmail.com.

Details of the Estimate

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

Service	**Diagnosis Code** (once determined)	**Service code**	**Quantity** (# of sessions or units. Give number or range)	**Cost per unit**	**Expected cost**
Initial evaluation	[use ICD codes]	90791	Fill in	$ fill in	$ fill in
Psychotherapy		90837 and/or 90834		$	$
Group Therapy		90853			

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Total estimated cost: $____[number or range]_____

Psychologist providing services: Name _____

NPI number: _____ TIN: _____

Address of office from which services will be provided _____

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 Clarity Counseling 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, 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.

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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.

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.