

NextStep Psychology, LLC

1650 W. Oak St., Suite 110
 Zionsville, IN 46077
 (317) 973-8888

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

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 7-9 sessions for a total cost of \$2,275 - \$2,625. However, in some cases, a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

The estimate below is the range of costs that I think is likely for your care over the time period covered by this estimate. Depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact Tony Jennings at NextStep Psychology, LLC at (317)973-8888 and/or at admin@nextsteppsychologyllc.com

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled for 6 months to 1 year of services. The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless we send you an updated Estimate.

Service	Diagnosis Code	Service code	Quantity	Cost per unit	Expected cost
Psychiatric Evaluation		90792	1	\$350	\$350
Follow-up Medication Management		99214	7 - 9	\$175	\$1,225 - \$1,575
Paperwork and/or consultation		N/A	2	\$350	\$700

Total estimated cost: **\$2,275 - \$2,625**

Psychologist providing services:

Dr. Brett Presley

NPI 1255333092

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 me when 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 \$400 more (per provider) than this Good Faith Estimate (GFE), you have the right to dispute the bill**

You may contact the clinician at the contact listed above to let them know the billed charges are at least \$400 higher than the GFE. You can ask them to update the bill to match the GFE, 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 GFE. 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 GFE is not a contract. It does not obligate you to accept the services listed above.

Keep a copy of this Good Faith Estimate (GFE) 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.

Patient Name (printed)

DOB

Patient Signature or Legal Representative

Date

Witness Signature

Date