

Instructions for simple Good Faith Estimate (GFE) template

You can modify this form to be the Good Faith Estimate (GFE) form for your practice if you are not required to, or will not be, including estimates for providers outside of your practice ([FAQs on the No Surprises Act and good faith estimates](#)).

This is designed for situations where only one provider in your practice is expected to provide services to a particular patient. But you can modify it to add the names, NPI, and TIN of multiple providers in your practice to the section on psychologist providing services.

Important Notes About Dispute Resolution:

As explained in [Understanding the No Surprises Act](#), it is important to track your billing vs. GFEs to avoid reaching the point where your billing is \$400 over the GFE. If you nonetheless find yourself in that position, we recommend that (in addition to promptly updating your GFE), you talk to your patient. We expect that most patients will understand, particularly while the GFE requirements are new.

If, however, your patient is upset or angry and wants to pursue dispute resolution, you should consider whether making a patient go through that process, like taking collection action against a patient, is worth the risk of triggering a board complaint or negative online review.

Note: If you have a solo practice, you can omit the “per provider” parenthetical in the disclaimer language (see page 2 of this form).

Simple GFE template for services provided by one psychologist

[Put your practice's logo, name and address here]

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

[Optional] Brief explanation of estimate for new patients:

The estimate below is the [range of costs]/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 [number or range] sessions for a total cost of \$[number or range]. 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.

[Optional] **Brief explanation for continuing patients:** The estimate below is the [range of costs]/cost 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 [your name, or other person in your practice who can answer questions about the GFE] at [phone number and email].

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled for [date or dates]. [Include the following for reoccurring services like psychotherapy.] 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 | | \$ | \$ |
| Psychotherapy | | 90837 and/or 90834 | | \$ | \$ |
| | | | | | |
| | | | | | |

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

Psychologist providing services: Name _____ [you can delete this if you are a solo practitioner or the practice name is the same as the treating psychologist]

NPI number: _____ TIN: _____

Address of office from which services will be provided _____ [This is only needed if you have multiple offices and you'll be providing services from a different office than the one listed at the top of the notice]

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

You may contact the [psychologist/psychology practice] 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.