



Date of Good Faith Estimate: ___/___/___

This estimate is for psychotherapy services through ___/___/___

Brief explanation of estimate for new patients: 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 10 to 26 sessions for a total cost range of \$ 1,050.00 to \$ 2,730.00. 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 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 Lisa Whalin, MA, LPC-S at (970) 245-1616 or lwhalin@arielcpa.org.

Details of the Estimate: The following is a detailed list of expected charges for psychological services beginning on ___/___/_____. 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
Initial evaluation	F ___:___	90791	1	\$105.00
Psychotherapy-1 hr.	F ___:___	90837		\$105.00
Psychotherapy – ¾ hr.	F ___:___	90834		\$ 78.75
Psychotherapy – ½ hr.	F ___:___	90832		\$ 52.50

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

Counselor providing services: _____

Supervising Provider: Lisa Whalin, MA, LPC-S, Colorado License LPC #2587

NPI number: 1851796866 TIN: 84-1255228

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Grand Junction CO 81504
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Wheatridge CO 80033
Phone: 303.703.9351
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2145 Academy Circle
Colorado Springs CO 80909
Phone: 719.260.6110
Fax: 719.260.6170



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/ 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 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.