Association Counseling Center, Inc., Vickie George M.Ed., MS
1325 Satellite Blvd. NW Suite 1002 Suwanee, GA 30024
770-813-8181

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:(Last 4 digits of SSN)		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled (Please see attached for a list of itemized services and fees)		
Patient Primary Diagnosis(es) TBD		

If scheduled, list the date(s) the Primary Service or Item that will be provided: [ ] Check this box if this service or item is not yet scheduled
Date of Good Faith Estimate: _____/_____/_____ **Summary of Expected Charges** (See the itemized estimate attached for more detail.)
Provider Name Vickie George
Total Estimated Cost: **$** TBD (See below)

Estimate

Provider Vickie George M.Ed, MS, LMFT, LPC, CST		Facility Association Counseling Center, Inc.
Street Address 1325 Satellite Blvd. NW Suite 1002		
City Suwanee	State GA	ZIP Code 30024
Contact Person Vickie George	Phone 770-813-8181	Email
National Provider Identifier		Taxpayer Identification Number 58-1748733

Details of Services and Items for: VICKIE GEORGE/ASSOCIATION COUNSELING CENTER, INC.

Service--Individual, Couple, Family or Group	Address where service/ item will be provided—See above	Diagnosis Code—Z69.5	Service Code-CPT codes listed below	Quantity-TBD	Expected Cost

Expected Charges from VICKIE GEORGE ASSOCIATION COUNSELING CENTER
$ TBD

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 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 the health care provider or facility listed 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.

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
Vickie George M.Ed., MS 770-813-8181

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

Keep a copy of this Good Faith Estimate in a safe place or takepictures of it. You may need it if you are billed a higher amount.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90834/ 90837	Psychotherapy, 50 minutes	$225
	90846/ 90847	Family Psychotherapy with/without Patient Present, 50 minutes	$225
	90853	Group Psychotherapy	$75
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 48-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records		$.50 per page
	Legal Fees		$380/hr.
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/ or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you any questions or concerns have been addressed. Thank you!

Patient's signature	Date
Print name of patient	
Therapist's signature	Date of signature