Farrow Psychological Services
9320 Carmel Mountain Road, Suite D Telephone (858) 480-1484

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference:	[ ] By mail	[X] By email
Patient Diagnosis Z65.8		
Primary Service or Item Requested/Scheduled (Please see attached for a list of itemized services and fees)		
Patient Primary Diagnosis		Primary Diagnosis Code
Problem related to unspecified psychosocial circumstances Or Other problem related to psychosocial circumstances		Z65.9 Z65.8
Patient Secondary Diagnosis		Secondary Diagnosis Code
N/A		N/A

If scheduled, list the date(s) the Primary Service or Item 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 — Estimated Total Cost Charles Farrow, Ph.D. — TBD
Total Estimated Cost: **$** TBD (See below)

The following is a detailed list of expected charges for psychotherapy, scheduled for _____ and recurring thereafter. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Estimate

Provider	Phone	Email
Charles Farrow, Ph.D.	(858) 480-1484	cfarrow@charlesfarrowphd.com
National Provider Identifier		Taxpayer Identification Number
1881614030		81-5089092 (for Farrow Psychological Services, Inc.)

Details of Services and Items for Charles Farrow, Ph.D.

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Individual psychotherapy	[Street, City, State, ZIP] 9320 Carmel Mountain Road, Suite D San Diego, CA 92129 or Via Telemental Health	[ICD code] Z65.8	[Service Code] 90834	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) or presenting clinical concerns.	This Good Faith Estimate explains your therapist's rate for each service provided. Please note the expected cost is based on the fee times the number of sessions needed as determined in collaboration with your therapist.

Total Expected Charges from Charles Farrow Ph.D.
$ TBD as stated above

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 (858) 480-1484

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 take pictures 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)
	90791	Initial Diagnostic Evaluation	$200-300
	90834	Psychotherapy, 38-52 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$200
	90846	Family Psychotherapy without Patient Present, 45-50 minutes	$300
	90847	Family Psychotherapy with Patient Present, 45-50 minutes	$300
	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
	NA	Production of Records	$75 / 15 minutes
	NA	Fees related to Legal Procedures	$75 / 15 minutes
	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 Print name of patient

_____ _____

Date of signature

_____ & _____

Guardian/Parent's signature Print name of Guardian/Parent

_____ _____

Date of signature

_____ & _____

Guardian/Parent's signature Print name of Guardian/Parent

_____ _____

Date of signature