NORMA J. CARUSO, PSY.D.
Licensed Clinical Psychologist
P.O. Box 8681
Richmond, Virginia, 23226

(804) 272-7287

GOOD FAITH ESTIMATE

Patient name _____ DOB _____

The estimate below explains my fees for the psychotherapy services that I provide. For 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. Initially, I see patients for a one-time Initial Evaluation. Subsequently, I typically see therapy patients on a weekly basis. The total number of sessions is unknown at this time and is based on your needs, preferences, and the progress that you make in treatment.

The ultimate total fee for treatment services will be the number of sessions multiplied by the ongoing session fee which is indicated below.

Details of the Estimate
The following is a detailed list of expected charges for psychological services scheduled for [date or dates].

Service	**Diagnosis Code**	**Service code**	**Quantity**		**Cost per session**	**Expected cost**
Initial Evaluation	To Be Determined	90791	1		$200	$200
Individual Psychotherapy	TBD	90834	Based on need/progress/preference		$135	Number of sessions x session fee
Family Psychotherapy	TBD	90847	Based on need/progress, preference		$135	Number of sessions x session fee

The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I send you an updated estimate.

If you have questions about this estimate, please contact me so that I can answer your questions or discuss your concerns.

Provider: Norma J. Caruso, PsyD, Clinical Psychologist

National Provider Identification Number (NPI): 1184849515

Tax Identification Number (TIN): 61-1571150

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.

If I believe that additional services would be beneficial for your treatment, I will discuss these recommendations with you and provide you with a separate estimate of the fees.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.
You may contact me at the contact information listed above to let them know the billed charges are higher than the Good Faith Estimate. You can ask for an updated 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 your bill exceeds the good faith estimate by four hundred dollars ($400). 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 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 Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than $400 than the estimate provided above.

_____
Signature

_____
Signature

Date of Good Faith Estimate: ___/____/___ for psychotherapy services

File: GFE