PEDIATRIC MENTAL HEALTH OF BOSTON, PLLC

GOOD FAITH ESTIMATE

Patient Name:_____ D.O.B.: _____
Patient Address: _____
Patient Phone Number:_____ Patient Email: _____

This Good Faith Estimate is provided for Patient on: _____
(Please note that if you require a reoccurring service, such as a monthly appointment, this Good Faith Estimate is good for twelve months. If there are changes to your charges before the expiration date, the Practice will provide you with an updated estimate).

Brief Explanation of items or services to be provided:

Date service(s) is to be provided (*if available*): _____

Total Estimated Cost: $_____

If you have any questions about this Good Faith Estimate, please contact:
Brenda Levy at drlevy@pedmhboston.com.

Please see the following pages for a detailed list of the expected charges for the item or service described above.

Provider Name:_____NPI:_____TIN:_____
Provider Address: _____

Service	**Address where service will be provided**	**Diagnosis Code** (once determined)	**Service code**	**Quantity** (# of sessions or units. Give number or range)	**Cost per unit**	**Expected cost**
					$	$
					$	$

Disclaimers Under the Federal No Surprises Act

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 you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

If your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

You may contact us to let us know the billed charges are higher than the Good Faith Estimate. You can ask us 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.

If you dispute your bill, we cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, we must cease collection efforts. We must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. We cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with us, 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/consumers or call 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/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

The Good Faith Estimate is not a contract that requires you to obtain the services listed above.

Please keep this Good Faith Estimate or take a picture of it. You may need it if you are billed more than $400 than the estimate provided.