Schaffner Psychotherapy Services, LLC
Angela D. Schaffner, Ph.D.
Licensed Psychologist
199 Armour Drive, Suite E, Atlanta, GA 30324
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Client Information

Name:

Date Of Birth:

Mailing Address:

Phone:

E-mail:

Client contact preference: Mail? Yes/No Email? Yes/No

Client Diagnosis/Treatment

Primary Service or Item Requested/Scheduled:
See itemized list of services and fees below

Client Primary Diagnosis/Code:
Z65.9 Problem Related to Unspecified Psychosocial Circumstances

Address Where Service Will Be Provided:
199 Armour Drive NE, Suite E, Atlanta, GA 30324 or Virtually at client's chosen location

Provider Estimate Information

Date of Good Faith Estimate: ______/_______/_______

Summary of Expected Charges:
$: TBD
Note: the expected cost of therapy is based on my fee times the number of sessions needed. As your therapist, I will work with you throughout your treatment to determine how many sessions and/or services you need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns. It is not possible nor therapeutically ethical to estimate the number of sessions needed upfront as ongoing variables contribute to that need and timeline. However, all payment is due at the time of service and all fees are discussed upfront. I am committed to being transparent about fees and services so that my clients do not experience financial surprises. Please see the table of fees and services below for more information.

Disclaimer:
This good faith estimate shows the cost of items and services that are reasonably expected for your healthcare 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 to start the process, go to www.cms.gov/nosurprises.

For questions or more information about your right to a good faith estimate or the dispute process, visit www.cms.gov/nosurprises or call 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

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
	90832	Psychotherapy, 16-37 minutes	$90
	90834	Psychotherapy, 38-52 minutes	$180
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$200
	90839	Psychotherapy for a Crisis (30-74 minutes)	$180
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$90
	90846	Family Psychotherapy without Patient Present, 50 minutes	$180
	90847	Family Psychotherapy with Patient Present, 50 minutes	$180
	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 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Legal Fees		$300/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.	

Good Faith Estimate Signature Page

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

Client Signature:

____

Guardian/Authorized Representative's Signature:

____

Print Name as Signed Above:

____

Date of Signature:

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