Allied Behavioral Health
1400 Peoples Plaza, Suite 204, Newark, DE 19702
1500B Shallcross Avenue, Wilmington, DE 19805
(302) 832-1282 apl 1790@yahoo.com
www.alliedbehavioral healthde.com
Federal Tax ID#51-038-6009 Group NPI #1063462661

Patient Name: _____

Date of Birth: _____

Diagnosis (or Z Code): _____

Good Faith Estimate

Attached is a good faith estimate of what your therapy with your out-of-network provider will cost you. It is an estimate, not a contract for services. This estimate shows the full estimated costs of the service(s) listed. It does not include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate.

Call your health plan

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Questions about this notice and estimate

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. If you have questions about this document, speak with the therapist that you are considering for treatment or one of the partners of Allied Behavioral Health.
If you have questions about your rights under the No Surprises Act, contact the Delaware Department of Insurance Bureau at 302-764-7300 or the U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit https://www.cms.gov.nosurprises.

Prior Authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you receive them. If prior authorization is required, ask your health plan about what information is necessary to obtain coverage.

By signing (on the last page of this document) , I give up my federal consumer protection and agree that I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

___ Allied Behavioral Health
___ Therapist Name _____

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

* I'm giving up some consumer billing protections under Federal law.
* I will be paying out-of-pocket for the services
* I was told by the facility or therapist explaining that there were no in-network providers and the rate that I would pay for my services if I agreed to be treated by a provider at this facility.
* I was either told verbally or by email what services would cost.
* I fully understand that some or all amounts I pay might not be reimbursed by my insurance plan or count toward my deductible or out-of-pocket limit.
* I can end this agreement by notifying the provider or facility in writing before getting services.

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Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
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 [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled (Please see attached for a list of itemized services and fees)		
Patient Primary Diagnosis (If unknown: TBD or Z659 - Problem related to unspecified psychosocial circumstances.)	Primary Diagnosis Code (If none: N/A)	
Patient Secondary Diagnosis (If none: N/A)	Secondary Diagnosis Code (If none: 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: _____/_____/_____
Provider Name Estimated Total Cost
Total Estimated Cost Based on Cost/Session: $

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

Therapist: Allied Behavioral Health Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier	Taxpayer Identification Number	

Details of Services and Items for:

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code] (If unknown: TBD or Z65.9)	[Procedure Code]	Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may	This Good Faith Estimate explains your therapist's rate for each service provided. Please

				need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns.	note the expected cost is based on the fee for the requested service(s).

Total Expected Charges from: Therapist: **Allied Behavioral Health** **Total Cost (Based on Cost/Session):**
Additional Health Care Provider/Facility Notes

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 careprovider 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 speak with your therapist at Allied Behavioral Health.

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)
	90791	Initial Diagnostic Evaluation	
	90832	Psychotherapy, 16-37 minutes	
	90834	Psychotherapy, 38-52 minutes	
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	
	90839	Psychotherapy for a Crisis (30-74 minutes)	
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	
	90845	Psychoanalysis	
	90846	Family Psychotherapy without Patient Present, 50 minutes	
	90847	Family Psychotherapy with Patient Present, 50 minutes	
	90853	Group Psychotherapy	
	96130-96133, 96136-96139	Psychological and Neuropsychological Testing	
	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 Cancellation Fee	You are Responsible for the $ Fee of the Appointment Missed
	Production of Records		
	Legal Fees		
	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!

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date of signature