Alexandra Tyler. LCSW
Cultivating Joy, Inc.
www.doxy.me/cjoyinc
alexandra.tyler@cultivatingjoy.net
www.cultivatingjoy.net

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 **Available upon request**		Primary Diagnosis Code Available upon request
Patient Secondary Diagnosis Available upon request		Secondary Diagnosis Code Available upon request

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 Alexandra Tyler, LCSW — TBD
Total Estimated Cost: $ TBD (See below)

The following is a detailed list of expected charges for psychotherapy/or any other service, scheduled for _____(date). Services are typically reoccurring.

For past and currently scheduled services:

"The estimated costs are valid for 12 months from the date of the Good Faith Estimate."

Future services are as follows:

For clients paying the full rate of $225/ 50 mins., this rate is set through 12/31/2022.

For clients paying a reduced rate, I tend to revisit financial need each quarter and if a new rate is agreed upon, you will be notified in writing and will receive an updated Good Faith Estimate.

Cultivating Joy, Inc. - Estimate

Provider/Facility Name		Provider/Facility Type
Cultivating Joy, Inc.		Alexandra Tyler LCSW
Street Address Telemental Health, virtual office at doxy.me/cjoyinc		
City	State	ZIP Code
Contact Person Alexandra Tyler LCSW – President/CEO	Phone	Email alexandra.tyler@cultivatingjoy.net
National Provider Identifier 1568848018		Taxpayer Identification Number 47-1411907

Details of Services and Items for Cultivating Joy, Inc.

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
individual psychotherapy	Via Telemental Health"	[ICD code] Available upon request	[Service Code Type: Service Code Number] 90837	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 Alexandra Tyler, LCSW: $ TBD as stated above
Additional Health Care Provider/Facility Notes N/A

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 Alexandra Tyler, LCSW at 404-397-8302 or email at alexandra.tyler@cultivatingjoy.net.

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.

OMB Control Number [0938-1401]
ExpirationDate [12/31/2022]

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	$225/ 53 min
	90832	Psychotherapy, 16-37 minutes	$112.50
	90834	Psychotherapy, 38-52 minutes	$168.75
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	$225.00
	90839	Psychotherapy for a Crisis (30-74 minutes)	$3.75/ min
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$3.75/ min
	90846	Family Psychotherapy without Patient Present, 50 minutes	$225.00
	90847	Family Psychotherapy with Patient Present, 50 minutes	$225.00
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records		$225/ hr
	Legal Fees		$450/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.

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

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ExpirationDate [12/31/2022]

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