deanna@alignedcounseling.org 615-474-8700

GOOD FAITH ESTIMATE

Date of Good Faith Estimate: __/__/____

This estimate is for psychotherapy services through __/__/__

Provider Name: Aligned Counseling LLC	License #: 4263 (TN), PC-0011234 (DE)
Provider Address: 3411 Silverside Road Baynard Building, Suite 104 Wilmington DE, 19810	
Provider Phone: (615) 474-8700	
Provider Tax ID #: 92-3040248	Provider NPI #: 1033866025

Patient Name:	
Patient Address:	
Patient Phone #: ( )	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested/Provided: Individual Therapy (90834)	

Brief Explanation: You are entitled to receive this "Good Faith Estimate" of the estimated charges for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Details of the Estimate: The following is a detailed list of expected charges for psychological services scheduled for (date or dates). The estimated costs are valid for 12 months form the date of this Good Faith Estimate, unless I send you an updated Estimate.

The fee for a 50 minute individual therapy session (in-person or via telehealth) is $125.00. Most clients will attend weekly or every other week therapy sessions, though some may attend more or fewer sessions per month, depending on individual needs.

Number of Sessions & Cost for Weekly Sessions (approximately 4 sessions per month):	Number of Sessions & Cost if Every Other Week (approximately 2 sessions per month):
1 = $125.00 12 sessions over 3 months = $1,500.00 26 sessions over 6 months = $3,250.00 38 sessions over 9 months = $4,750.00 52 sessions over 12 months = $6,500.00	1 = $125.00 6 sessions over 3 months = $750.00 13 sessions over 6 months = $1,625.00 19 sessions over 9 months = $2,375.00 26 sessions over 12 months = $3,250.00

Counselor providing services: Deanna Candeloro, M.Ed., NCC, LPC MHSP (TN# 4263), LPCMH (DE PC 0011234) at Aligned Counseling LLC via telehealth.

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.

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.

You may contact the counselor or counseling practice at the contact listed above to let me know the billed charges was at least $400 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 initiate a dispute resolution process with the U.S. Department of Health and Human Services if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). 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 prices 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 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

Questions?: If you have any questions about this estimate, please contact me at 615-474-8700 or deanna@alignedcounseling.org.

Signature: _____

Client Printed Name: _____ Date:_____