Tamara Allen Bush LLC Tamara Allen Bush LPC-S, NCC, CSAT
P.O. Box 885, Keller, TX 76244 * 817-713-7223 * Fax: 817-887-3814
tamaraallenlpc@gmail.com * http://tamaraallenlpc.com

Good Faith Estimate for Mental Health Care Services

Client information

Name ______________________________ Client ID Number: ___________________________

Address
____

Phone __________________ Email: _________________________________ DOB: ____________

Treatment Information

Service Requested: Outpatient Counseling services

Frequency: weekly Has the service been scheduled, yet? Yes

Presenting Issue or diagnosis: Anxiety, Depression and relationship issues.

Provider Information

Provider Name: Tamara Allen Bush LPC-S, NCC, CSAT

Address: 520 E. Vine St., #885, Keller, TX 76244.

Estimate of Cost $150 per hour Counseling session Length of treatment: 6 months

Estimated total: $3600.00 Date of Good Faith Estimate _____________________

Change

Date of Change ________________ Updated Estimate __________________________________

Reason for Update____
* Records Requests are billed at 15 cents a page and the postage, if mailed. Electronic records are no charge.

Required Disclaimer

This Good Faith Estimate shows the predicted costs of services reasonably expected for your counseling needs from our office. The estimate is based on information known at the time the estimate is offered.

The Good Faith Estimate does not include unknown or unexpected costs that may arise during your 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 are not required to obtain services from our offices.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact your counselor or facility 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 [888-388-6332]. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit *www.cms.gov/nosurprises* or call [888-388-6332].

Received:

______________________________ _______________
Client Signature Date

____
Client Printed Name

______________________________ _______________

Provider Signature Date