Change for Living COUNSELING, PLLC

Good Faith Estimate for Health Care Items and Services*
(Via In Person, Video or Telephonic)

Patient		
Patient Name	Legal Name (if different)	Last Name
Patient Date of Birth:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Patient Primary Diagnosis		Primary Diagnosis Code

Service Code	Description	Cost Per Hour*	Total Estimated Cost for Weekly Sessions for 12 Months*
90791	Child/Family/Couples Intake Session	$285.00	$285.00
90791	Individual Intake Session	$200.00	$200.00
90837	Individual - **Per Hour**	$170.00	$8,840.00
90847	Family/Couples Session - **Per Hour**	$200.00	$10,400.00
	HRT/Surgical Per Letter (Session & Letter)	$200.00	$200.00
	HRT/Surgical Per Letter (Current Clients)	$100.00	$100.00

***Sessions are usually a minimum of 60 minutes. Fees are pro-rated for time frames more or less than an hour.**

Other Services & Fees Available Upon Request.

Tel: (919)807-1454
Fax: 888-789-5440
CFLcounseling@gmail.com
www.ChangeForLivingCounseling.org
Raleigh, NC 27604

Provider Name: Michelle Topal, MSW, LCSW
NPI: 1790001857
Tax ID: 27-2209483

Date Provided: _____

Good Faith Estimate Information & Signatures

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

If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

This Good Faith Estimate does not require you to receive or continue services with me.

This Good Faith Estimate is based on information known at the time the estimate was created. However, additional items or services may be recommended as part of treatment that will be scheduled separately and are not reflected in this Good Faith Estimate. The full annual cost of services will depend on the type, length, and frequency of sessions, written reports and coordination of care. However, I have included here the costs for items and services that are reasonably expected in the course of treatment with me.

The Good Faith Estimate is only an estimate, and does not include any unknown or unexpected costs that may arise during treatment. Actual services or charges may differ from this Good Faith Estimate as clinical circumstances require or as requested by you.

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 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.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

With my signature, I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above

Signature(s):_____ Date:_____
(Patient's Guardian/Authorized Representative)

Print Name of Signator(s):_____

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