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**GOOD FAITH ESTIMATE**

Therapy Practice: Be Moved Therapy LLC

NPI: 1801266820 TIN: 87-3396022

Provider: Kimberly Schmidt Bevans LMHC, BC-DMT

NPI: 1053558395 TIN: 47-3085628

Office Location: 1895 Centre St, Suite 201, West Roxbury, MA 02132

Phone: 617-651-0996

Email: kimberly@bemovedtherapy.com

Services Requested: Individual therapy for mental health

Date of Estimate:

You are receiving this notice because Kimberly Schmidt Bevans LMHC, BC-DMT is not in-network with your health insurance plan and is therefore considered out-of-network. This means the provider or facility does not have an agreement with your plan to provide services. Under the law, healthcare providers need to give patients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services, including mental health services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including therapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

You are entitled to receive this Good Faith Estimate of what the charges **could be** for therapy services provided to you. Kimberly Schmidt Bevans, LMHC, BC-DMT recognizes every client's therapy journey is unique and it is not possible for a therapist to know how many sessions will be appropriate or needed in advance. Your total cost of services will depend on the number of sessions you attend, your individual circumstances, the type and amount of services provided to you.

While it is not possible for a therapist to know in advance how many therapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Together we will continually assess the appropriate frequency of therapy and will work to determine when you have met your goals. **This estimate is not a contract.**

**Your Financial Responsibility Summary:**

The "Good Faith Estimate" requires practitioners to provide an estimate and not a range. Many clients will attend one therapy visit per week or one visit every two weeks, but the frequency of therapy visits that are appropriate in your case may be more or less, depending upon your needs. Below you will see the fees outlined for therapy treatment. **This does not include other fees, such as fees for canceling less than 48 hours in advance, report writing, preparation of records or treatment summaries, consulting with other professionals with your permission, and time spent performing any other requested service.**

The one-time fee for an initial diagnostic assessment/intake is **$260 (CPT Code 90791).**  Beyond this, the fee for a traditional 50-minute therapy session (in-person or via telehealth) is **$230 (CPT Code 90834)** and 75-minute session is $325**.** Appointments canceled with less than 48-hrs notice will be charged a full session fee, **$230**.

You may project any potential future cost(s) by multiplying the appropriate recurring session fee by the total number of sessions.  This will result in your total estimated cost for mental health service(s).

**For example, $230 session fee x 4 sessions = $920.00**

If you attend therapy for a shorter or longer period, your total estimated charges will decrease or increase according to the number of visits and length of treatment. I raise my fees periodically throughout the year. I will inform you of any increases with at least 30 days notice  and provide you with an updated Good Faith Estimate reflecting the new fees.

**Where services will be delivered:**

I am currently only providing therapy services via **telehealth** until further notice. Session fees for telehealth sessions and in-office sessions are the same.**1**

**Patient Information:**

Name:

Date of Birth:

Patient Contact Preference: **Electronic**

Patient Diagnosis Code (if known):

**Disclaimer:**

This Good Faith Estimate shows the cost of items and services that are reasonably expected for your mental health care needs for therapy sessions. 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.

This Good Faith Estimate is not a contract and does not obligate you to receive the services listed nor does it obligate you to receive the services listed by this provider.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill (which means $400 or more beyond the estimated charges). 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](http://www.cms.gov/nosurprises) or call 800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 800-985-3059.

**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. Your signature serves as an acknowledgment that you were informed of the No Surprises Act and your Good Faith Estimate.**

*Your e-signature in Therapy Portal confirms that you have read and understand the terms of this notice.*