Brave Minds Psychological Services, LLC
567 Park Avenue, Suite 204
Scotch Plains, NJ 07076
O: (908) 242-3634
Tax ID: 81-5115434
NPI: 1619414885

Good Faith Estimate for Current Clients
Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services.

This provider is not paneled with any insurance panels and is private pay only.

This is NOT a bill.

At Brave Minds, we recognize that every person's journey is unique. Mental Health Professionals cannot make a diagnosis or recommendation for treatment prior to meeting you. How long and how often you (or your child) need to engage in therapy can be influenced by several factors including those listed below.

- Your schedule, availability and life circumstances
- Therapist availability
- Nature of your specific challenges and how you choose to address them
- Ongoing life challenges
- Personal finances

CLIENT INFORMATION (Client Mailing Address, Phone, Email: On File):

Client Full Name & Date of Birth: _____

PRIMARY SERVICE: Outpatient Psychotherapy

Client Primary Diagnosis:

__X_ I have discussed with my therapist my diagnosis (or my child's diagnosis) and I do not wish for it to be on this form.

*Client diagnosis is subject to change and fees will not change even if diagnosis changes.

Client Full Name & Date of Birth: _____

The following is a detailed list of expected charges. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Individual, or Family Therapy (CPT: 90834/90837 or 90846/90847) fee: _____

	Alexandria Bleich, LAC (NPI:1164015475)		Jessica Pizzo, LCSW (NPI: 1104165448)
	Casey Conte, LSW (NPI: 1528729753)		Kerry Isgur, LCSW (NPI: 1376939736)
	Claudia Salgado, LMFT (NPI: 1659850600)		Lauren Grossbach, LMFT (NPI: 1053735076)
	Elaine Harrison-Yau, LCSW (NPI: 1366743205)		Lisa Weiss, LCSW (NPI: 1083275572)
	Fawn McNeil-Haber, PhD (NPI:1710130307)		

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready to discharge. If you were to meet with your therapist at the frequency recommended

Weekly = 52 Sessions	Every Other Week =26 Sessions
Monthly = 12 Sessions	Other

at the fee listed above, the cost for a year would be: $___ x ___ sessions = _____.

The amount above is only an estimate. It isn't an offer or contract for services.*

Where services will be received: At address listed above and/or online, via telehealth

Client Full Name & Date of Birth: _____

Other Potential Costs at Brave Minds

The following fees and services may be requested and/or required through the course of treatment and are not included in the Good Faith Estimate above.

- Intake session (CPT 90791) $200-$275
- Late Cancel/No Show Fees: Cost of individual session prorated per 50 minutes
- Phone calls/sessions: Cost of individual session prorated per 50 minutes
- Letter Writing/Treatment Summaries: Cost of individual session prorated per 50 minutes
- Consultations with other outside professions on your treatment team: Cost of individual session prorated per 50 minutes
- Attendance/participation/preparation in legal proceedings: $450/hour, $1350 retainer

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

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.

Client Full Name & Date of Birth: _____

Client Signature: _____

Today's Date: _____

If applicable,

Guardian Name: _____

Guardian Relationship:_____

Guardian Signature: _____