Chicago Center for Cognitive Wellness
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Good Faith Estimate for Health Care Services

Chicago Center for Cognitive Wellness
National Provider Identifier: [**INSERT]**
Taxpayer Identification Number: 27-3338307

Client Name:_____ Client Date of Birth: _____

The following is a detailed list of expected charges for psychotherapy services provided by: [**XXX Therapist Name XXX**] NPI Number: [**INSERT**]

[90791: Assessment] Cost: *Based on Fee Schedule*

[90837: 60-minute Psychotherapy] Cost: *Based on Fee Schedule*

I expect that my care of you will require **[XX]** weekly sessions. Although the number of total sessions that are required to meet your goals are unknown at this time, the average number of sessions for similar diagnosis is **[XX].** Diagnosis can change over time. At **[rate from Fee Schedule]** for first initial session, the estimated cost would be [**insert Assessment Sessions Cost]** plus [**insert Cost of (XX) sessions**] for a total cost of [**XXXXX to XXXXX**]. Fees will be billed to your insurance on file. You are responsible for any amount not covered by your insurer. We evaluated a verification of benefits with your insurer on **[DATE]** and determined **[ENTER VOB].** This estimate is not a guarantee of total cost as total session may vary.

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

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted 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 you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

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 of Client: _____ Date: _____