Sherri H. Rawsthorn, LCSW, CCE

265 W. Pike St, Suite 4
Lawrenceville, Georgia 30046
(678) 377-6992

Surprise Billing Notification for Self-Pay Services

"Good Faith Estimate"

You have the right to receive a "Good Faith Estimate" for the total expected costs of any non-emergency services detailing how much your medical or healthcare care services will cost.

Under Section 2799B-6 of the Public Health Services Act, all medical and mental health clinicians are required to give patients who do not have insurance or who are not using insurance a "good faith estimate" (GFE) of the cost of services and how long services may last.

If you have health insurance and choose to not use it, I can provide you with a receipt upon request, which you can submit to your health insurance company if you choose. However, please be aware that your plan might not reimburse you, the payment may be of lesser amount than what you have paid and/or they might not count any of the amount you pay towards your deductible and out-of-pocket limit.

For additional information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call the "No Surprises" Help Desk at 800-985-3059. You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the GFE without it impacting the quality of care you receive.

Good Faith Estimate (GFE) for Services

Date of Estimate:	Begins on the date of first session		
Provider:	Sherri Rawsthorn, LCSW	NPI: 145-7411530	Tax ID: 65-1167081
Service Address:	265 W. Pike Street, Suite 4, Lawrenceville, GA 30046		
Patient Name:			Date of Birth:
Diagnosis:	Deferred		

This is a "Good Faith Estimate" of what you could pay if you choose to participate in psychotherapy services with Sherri Rawsthorn, LCSW as a self-paying client.

The following services may be provided:

- Initial diagnostic evaluation (CPT code: 90791) - $150.00 /45-50min session
- Individual psychotherapy (PCT code: 90834) – $150.00/45-50min session
- Family Psychotherapy with or without patient present (CPT codes: 90846/90847) or Reunification Therapy - $250.00/45-50min session
- Parenting Services (Parenting Coordination, Co-parent Coaching) - $250.00/hour
- Forensic evaluations or Consultation - $350.00/Hour

***Services may be rendered in-person or via tele-health.

The estimated cost per session is $150.00-$350.00 per 45 minute-1 hour session depending on the service.

Examples:

The total estimated cost for service if you had one 45-50 minute individual therapy session each week for 52 weeks (one Year) is $7800.00.

The total estimated cost for service if you had one 45-50 minute session every other week for six months is $1800.00.

The total cost for parenting coordination if you had one (1-hour) session each month for one year is $3000.00.

Additional services that might be added to your care that are not included in this estimate are:

- Consultation with other providers or professionals upon your consent and request - $150.00-$350.00/hr.
- Review of records or other relevant documents – $150.00-$350.00/hr.
- Writing reports - $150.00-$350.00/hr.
- Writing and reading email correspondence - $150.00-$350.00/hr.
- Court appearance or testimony – daily rate per the service agreement

DISCLAIMER:

- This GFE 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. There may be additional services recommended during the course of services being rendered that may not be included in this estimate.
- This GFE is not a contract and your actual charges may be different. The actual number of visits or hours of service may vary significantly depending on the frequency of visits or the amount of out-of-session work that is required for your case.
- Parenting coordination and conflict assessment services are not included in this estimate.
- If there is a dispute about this estimate, you may contact Sherri Rawsthorn, LCSW or the Department of Health and Human Services within 120 days of the service outlined in this estimate. You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the GFE without it impacting the quality of care you receive.
- You are advised to keep a copy of this GFE for your records.

My signature below confirms that I have read this "No Surprise Billing Notice" and have had the opportunity to ask questions. I understand that this estimate of fees may not cover every circumstance of my treatment or services that I receive and that I may ask questions at any time to clarify billing practices.

_____ _____

Client Signature Date