Lacey Amos Counseling
732 Montgomery Hwy, Suite 217 • Vestavia Hills, AL 35216 • (205) 440-3686
laceyamoscounseling@gmail.com • laceyamoscounseling.com

Good Faith Estimate for Health Care Services

NPI: 1356655831; AL LPC License: 3107; Tax ID: 86-1696052

Client Name: _____

Date of Birth: _____

Client Address: _____

_____

Thank you for allowing me the opportunity to provide you with therapeutic services. You are entitled to receive this "Good Faith Estimate" of what the charges could be for therapeutic 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. Your total cost of services will depend upon the number of therapy sessions you attend and your individual circumstances.

This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of therapy sessions. The number of sessions that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The following is a detailed list of expected charges for Psychotherapy Services provided by Lacey Amos, LPC-S:

- **50-60 Minute Psychotherapy Session Cost: $140.00**
- **Late Cancel Fee Cost (< 24 hours): 50% of Session Price**
- **Missed Appointment Cost: Full Session Price**

This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns. A diagnosis may be provided upon request. The total number of sessions required to meet your goals are unknown at this time and could require up to 52 sessions in the next 12 months. The total cost is outlined below at the frequency of 52 sessions over the next 12 months:

At $140.00 per session, the cost for 52 sessions would be $7280.00

The estimate above does not include the cost of any additional service you may request (i.e. Prepare & Enrich Assessment, phone consultations, documentation/records, communication with other providers or meetings/court proceedings.) ***This agreement expires on December 31, 2026.***

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STANDARD NOTICE

"Right to Receive a Good Faith Estimate of Expected Charges"
Under the NoSurprises Act

You have the right to receive a "Good Faith Estimate"explaining how much your medical care will cost.

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider, and any other provider you choose for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good FaithEstimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

Your signature below indicates that you have received, read and fully understand all of the information contained in this "Good Faith Estimate for Health Care Services" document.

Client Signature(s) _____ _____

Date: _____