Simply Thrive Therapeutic Associates
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Cary, NC 27511
Phone: (919)-636-0762
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simplythrivetherapy.com

Good Faith Estimate

Out Of Network Services

Client Full Name: _____

Client Date Of Birth: _____

Diagnosis: Same Rate Regardless of Diagnosis

Simply Thrive Therapeutic Associates

NPI: 1306297213

TIN: 461616745

Description of Service & Cost

Intake Appointment (CPT code 90791): $120

55-minute psychotherapy session (CPT code 90837): $120

Blueprint Assessment Services (CPT code 96138): $10 per week

• Your cost will include one intake evaluation at $120. I anticipate your treatment will require weekly 55-minute psychotherapy sessions throughout the next 11 weeks at $120 per session for a total of taking into consideration vacations, holidays, emergencies and sick time for an estimated total of $120 x 12 weeks=$1440 total.

•You will also be charged for Blueprint Assessment services at $10 per week,for a total of $120.

Total Quarterly Investment

$1560

►Review your detailed estimate.

►Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

►Questions about this notice and estimate? Email Simply Thrive's billing department at admin@simplythrivetherapy.com.

►Questions about your rights? Visit https://www.cms.gov/nosurprise... for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

• I'm giving up some consumer billing protections under federal law.

• I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.

• I was given written notice explaining that my provider isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility

• I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.

• I can end this agreement by notifying the provider in writing before getting services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider might not treat you. You can choose to get care from a provider in your health plan's network.

I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I am giving my authorized consent for treatment and payment for those services detailed above.

Client Signature _____ Date _____