Carla Natalucci-Hall, Psy.D.
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www.drcarlanatalucci.com
Federal Tax ID 263184054
NPI #1346323896

Good Faith Estimate for Services Provided by one Psychologist

Date: _____

Patient name _____ DOB _____

Date of Good Faith Estimate: _____

This estimate is for psychotherapy services through 12/31/2022

Brief explanation of estimate for new patients:

The estimate below is the cost or the range of costs that is likely for most new patients. Until I do an initial evaluation and we start to work together, I will not have a clear picture of your specific diagnosis, issues and needs. I typically see therapy patients for 1-2 sessions a week. But in each case, a patient's situation may be more complicated, so we may need additional sessions during the time covered by this estimate.

Brief explanation for continuing patients: The estimate below is the range of costs that I think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions may be needed.

Contact: If you have questions about this estimate, please contact Dr. Carla Natalucci-Hall, who can answer questions about the Good Faith Estimate at 917-853-6002 and dr.carla.natalucci@gmail.com.

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled starting _____ The estimated costs are valid for 12 months from the date of this Good Faith Estimate, unless I send you an updated estimate.

Service	Diagnosis Code	Service code	Quantity	Cost per unit	Expected cost
Initial evaluation	[use ICD codes]	90791	1	$275.00	$275.00
Psychotherapy	_____	90834	1	$275.00	$275.00
Family Psychotherapy with Patient Present	_____	90847	1	$275.00	$275.00

Group Psychotherapy	_____	90853	1	$85.00	$85.00
Family Therapy without Patient present	_____	90846	1	$275.00	$275.00
Psychological Testing	_____	96130-96133	1	$200.00	$200.00
Legal Testifying/Report writing/ Called as an Expert Witness	_____	_____	1	$250.00	$250.00
Cancellation Fee if the session is cancelled 48 hours or less to the appointment time	_____	_____	1	Fee of the appointment missed	Fee of the appointment missed

I expect that my care of you will require weekly therapy sessions two times per week through the end of the year at $ 275.00 per session.

Total estimated cost: $ _____

If additional sessions are needed the cost will be $ 275.00 per session and decided jointly.

My cancelation policy is as follows:
Please notify me 48 hours ahead of time

Psychologist providing services: Carla Natalucci-Hall, Psy.D.

NPI number: 1346323896 TIN: 263184054

Address of office from which services will be provided:

ZOOM Private Room For Carla Natalucci-Hall, Psy.D.

Or

Doxy.me Private Room For Carla Natalucci-Hall, Psy.D.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to [us/me] when [we/I] did the estimate.

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 [psychologist/psychology practice] at the contact listed above 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 CMS at 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 CMS at 1-800-985-3059.

This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than $400 than the estimate provided above.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____	or	_____
Print name of patient		Print name of guardian/authorized representative
_____	or	_____
Date and time of signature		Date and time of signature