

## Good Faith Estimate

Date of this Estimate \_\_\_\_\_

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. 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 this happens, federal law allows you to dispute (appeal) the bill. This estimate is not a contract and does not obligate you to obtain any services from me.

### ***Provider and Patient Information***

Business Name: Breakthrough Therapy, LLC DBA Mary Katherine Therapy	
Business Physical Address: 11 Davis Keats Drive Greenville, SC 29607	
Provider Name: Mary Katherine Lance, LMFT	
Provider License No.: 8053	Provider Phone No.: (864) 202-6537
Provider Tax ID No.: 93-4245072	Provider NPI #: 1104595909

Patient Name:	Patient Date of Birth:
Patient Address:	
Patient Diagnosis (if known/applicable):	
Services Requested:	

### ***Estimate***

CPT Code	Service	Cost of one session	Cost of 52 sessions (every week)	Cost of 26 sessions (every two weeks)
90834 or 90837	Individual Psychotherapy Session (50 minutes)	\$150	\$7,800	\$3,900
90847	Family/Couple Psychotherapy Session (50 minutes)	\$150	\$7,800	\$3,900
90847	Family/Couple Psychotherapy Session (75 minutes)	\$225	\$11,700	\$5,850

## *Disclaimers*

Above you see how much a year of therapy will cost at my standard rate if you attend therapy every week or every two weeks. This Good Faith Estimate is not intended to serve as a recommendation or prediction for treatment, its frequency, nor its duration. You are entitled to discontinue treatment at any time.

In certain circumstances, you may have a different fee or frequency arrangement, and the cost you incur may be less than what is reflected above. Additionally, in certain circumstances, there may be additional items or services I may recommend as part of your care that must be scheduled or requested separately; these are not reflected in this Good Faith Estimate.

If your insurance plan includes out-of-network benefits, this Good Faith Estimate does not account for any reimbursement you may receive after submitting a superbill.

You have the right to initiate a dispute resolution process if the actual amount charged to you exceeds the estimated charges stated in your Good Faith Estimate by \$400 or more. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services you receive.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit <https://www.cms.gov/nosurprises/consumers> or call 1- 800-985-3059.

Please reach out to me at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.