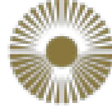

CLARITY THERAPY
NYC

Good Faith Estimate for Health Care Items and Services

Client:
Provider:
Provider License:

PATIENT INFORMATION
Patient
First name:
Last name:
Date of birth:
Patient Contact Information
Street or PO box:
Patient Diagnosis
Primary service or item requested/scheduled:

PROVIDER ESTIMATE
Provider/facility: Clarity Therapy
Street address: 276 Fifth Ave, Suite 605
City: New York
State: NY
ZIP code: 10010
Contact person: Your Therapist
Phone: (917) 847-7556
Email: hello@claritytherapynyc.com
National Provider Identifier (NPI): 1730532284
Taxpayer Identification Number (TIN): 812825187

DETAILS OF SERVICES AND ITEMS FOR [PROVIDER/FACILITY]

1. Service/item:

Diagnosis code [ICD-10]:

DISCLAIMER

This Good Faith Estimate 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. 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.

ABOVE, YOU WILL SEE HOW MUCH A YEAR OF THERAPY WOULD COST IF YOU WERE TO MEET WITH YOUR THERAPIST FOR 52 SESSIONS IN A YEAR (WEEKLY, WITHOUT SKIPPING ANY WEEKS) AT THE CURRENT RATE. WE UNDERSTAND THAT THERE ARE CIRCUMSTANCES WERE A REDUCED FEE ARRANGEMENT MAY BE NECESSARY FOR A TIME AND THAT THE FEE YOU PAY FOR SERVICES MAY VERY WELL BE LESS THAN WHAT IS REFLECTED BELOW. LIKEWISE, NOT ALL CLIENTS WILL MEET WITH THEIR THERAPISTS ON A WEEKLY BASIS. EACH INDIVIDUAL THERAPIST AT CLARITY THERAPY HAS THE ABILITY TO DETERMINE, ALONG WITH YOU THE CLIENT, WHETHER A REDUCED FEE ARRANGEMENT IS AN OPTION, AS WELL AS THE FREQUENCY OF SESSIONS.

THIS GOOD FAITH ESTIMATE DOES NOT ACCOUNT FOR ANY OUT-OF-NETWORK INSURANCE BENEFITS THAT YOU MAY HAVE. IF YOU HAVE OUT-OF-NETWORK BENEFITS, YOU MAY BE ABLE TO BE REIMBURSED FOR UP TO 60-80% OF THESE CHARGES, DEPENDING ON YOUR SPECIFIC INSURANCE BENEFITS. IF YOU WOULD LIKE MORE INFORMATION ABOUT OUT-OF-NETWORK BENEFITS AND REIMBURSEMENT, PLEASE SPEAK TO YOUR THERAPIST DIRECTLY.

IF YOU ARE BILLED FOR MORE THAN THIS GOOD FAITH ESTIMATE, YOU HAVE THE RIGHT TO DISPUTE THE BILL.

You may contact your therapist listed 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 HHS at (800) 368-1019.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

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 a higher amount.

Client:
Provider: