Good Faith Estimate

This is a compliance document required by the **No Surprises Act** (effective Jan 1, 2022, in the U.S.), which requires providers to give uninsured or self-pay clients a written estimate of expected costs.

Good Faith Estimate
***Ther*Alliance Counseling Services LLC**
105 W. 3rd St.
Media, PA 19063
Phone: 856.886.8402
Email: theralliance.pa@gmail.com

Patient Information

- **Patient Name:** _____
- **Date of Birth:** _____
- **Date of Estimate:** _____

Provider Information

- **Provider Name:** Cristine Cappo, M.A., LPC, LBS, NCC
- **Practice:** TherAlliance Counseling Services LLC
- **NPI #:** 1336721732
- **License #** PC014380

Services Requested / Anticipated
Below is a **Good Faith Estimate** of the expected charges for mental health services that may be provided.

Service Description	CPT Code	Estimated Cost per Session	Estimated Number of Sessions	Total Estimated Cost
Initial Intake / Diagnostic Assessment	90791	$225.00	1	$225.00
Individual Psychotherapy (60 minutes)	90837	$120.00	Unlimited	$120.00/session
Family / Couples Therapy (without client present, 50 minutes)	90846	$100.00	As Needed	$100.00/session
Family / Couples Therapy (with client present, 50 minutes)	90847	$150	As Needed	$150.00/session

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THERALLIANCE
COUNSELING SERVICES

Important Notes

- This estimate is **not a contract** and does not oblige you to receive services.
- The actual number of sessions needed may vary depending on your progress and treatment goals.
- Additional services may be recommended as clinically appropriate.
- This Good Faith Estimate is based on information available at the time of scheduling and is valid for **12 months** from the date of issue.
- If your actual billed charges are **$400 or more above this estimate**, you may initiate a dispute resolution process.

Your Rights

Under federal law, you have the right to:

- Receive a written Good Faith Estimate for at least **1 business day before** your scheduled service (or upon request).
- Dispute charges if they substantially exceed the estimate provided.
- Obtain a copy of this estimate for your records.

For more information, visit: https://www.cms.gov/nosurprises

Acknowledgment of Receipt

I, _____ (patient name), acknowledge that I have received and reviewed this Good Faith Estimate from TherAlliance Counseling Services LLC.

Patient Signature: _____

Date: _____

Please note that all out-of-pocket expenses may be eligible for reimbursement by your insurance provider upon request of a Superbill from your therapist.

Contact your insurance provider to find out more on out-of-network insurance reimbursement coverage.
