# Good Faith Estimate for Neuropsychological Services (Flat Fee)

Required under the No Surprises Act

## Provider Information

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Date of Estimate:

Anticipated Dates of Service (if scheduled):

☐ Services not yet scheduled:

## Patient Information

Patient Name:

Date of Birth:

Parent/Guardian Name:

Phone:

Address:

Email:

## Diagnosis

A diagnosis may or may not be determined as part of the evaluation process. A diagnosis is not required in order to receive this Good Faith Estimate.

## Reason for Services

Comprehensive neuropsychological evaluation to assess developmental, cognitive, emotional, behavioral, social, and adaptive functioning in response to concerns regarding possible:

## Anticipated Services and Estimated Cost

This Good Faith Estimate applies to a comprehensive pediatric neuropsychological evaluation, which typically includes:

- The primary item or service is a comprehensive pediatric neuropsychological evaluation provided under a flat-fee private-pay
- model, and this estimate includes all reasonably expected items and services associated with that evaluation.
- Review of relevant records and background information.
- Clinical interview with parent(s)/guardian(s) and child (as appropriate).
- Neuropsychological and/or psychological test administration and scoring.
- Interpretation and integration of test results and clinical data.
- Preparation of a comprehensive written evaluation report.
- Feedback session with parent(s)/guardian(s) to review findings and recommendations.

Specific billing codes (CPT) are not listed because services are provided under a flat-fee private-pay model and are not billed to insurance.

This estimate is based on information known at the time it was created.

## Estimated Total Cost of Services (Flat Fee)

**$2500**

This amount reflects the total anticipated cost of the evaluation services described above. This estimate is valid for 30 calendar days from the date of issuance unless the scope of services materially changes.

## Important Notes

- This Good Faith Estimate shows the expected cost of services listed above. It is not a bill.
- If additional services become necessary that are not included in this estimate, you will be informed in advance and provided with an updated Good Faith Estimate before those services are provided.
- Neuropsychological evaluations are typically not covered by insurance when conducted for educational or developmental planning purposes.

## Disclaimers and Patient Rights

If you are uninsured or self-pay, you have the right to receive a Good Faith Estimate of expected charges. If you receive a bill that is $400 or more above this Good Faith Estimate, you may dispute the bill through the Patient-Provider Dispute Resolution (PPDR) process. For more information, visit www.cms.gov/nosurprises or call 1-800-985-3059. The Patient-Provider Dispute Resolution (PPDR) process must be initiated within 120 calendar days of receipt of the original bill. www.cms.gov/nosurprises or call 1-800-985-3059.

## Delivery of Estimate

This Good Faith Estimate is being provided because:

- ☐ You are uninsured
- ☐ You are choosing not to use insurance and are paying out-of-pocket
- ☐ You requested a Good Faith Estimate

The Good Faith Estimate was issued on: _____

Services are expected to begin on or after: _____

## Questions

If you have questions about this estimate, the evaluation process, or financial policies, please contact:
Pediatric Neuropsychology Associates PLLC
954-284-0048
admin@pediatricneuropsychologyassociates.com

## Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

## Parent or Legal Representative Acknowledgment of Receipt and Review (for Minors or Individuals Lacking Legal Capacity)

I acknowledge receipt of this Good Faith Estimate and understand it reflects a non-binding estimate of anticipated charges.

Printed Name of Parent/Legal Representative: _____

Signature of Parent/Legal Representative: _____

Relationship to Patient: _____

Date: _____

*A copy of this signed form will be retained in the patient's health record.*

## For Office Use Only

Date Received: _____

Received By: _____

Staff Role: _____

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: _____