Surprise Billing Protection Form
Good Faith Estimate (GFE)

Provider Name: Jess Albright, LCPC, ACS	License/#: LC5406
Provider Address: 124 N. Court Street, Frederick, MD 21701	
Provider Phone #: (240) 457-9015	
Provider Tax ID#: 45-4593276	Provider NPI #: 1396018388

The purpose of this document is to let you know about your protections from unexpected medical bills. The No Surprises Act was enacted in 2020 with the goal of protecting patients from unexpected bills for healthcare services, such as charges for out-of-network emergency care. Many of its provisions do not apply directly to mental health or private practice providers.

You are getting this notice because this provider, Jess Albright, LCPC, ACS, is **not** within your health insurance plan's network. This means that this provider, Jess Albright, LCPC, ACS, does **not** have an agreement with your healthcare plan. All fees for services with Jess Albright, LCPC, ACS are due at time of service and will **not** be submitted through your health insurance plan. Please refer to Informed Consent for outline of fees.

You are entitled to receive this Good Faith Estimate (GFE) of what the charges could be for psychotherapy services provided to you. While it is not possible for a Jess Albright, LCPC, ACS to know in advance how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. This estimate is not a contract and does not obligate you to obtain any services from Jess Albright, LCPC, ACS, nor does it include any services rendered to you that are not identified here. Treatment is always voluntary and you can remove yourself from services at any time. Be advised that you can always contact your health insurance plan for a list of in-network providers.

Please see the following page for your cost estimate.

Estimate of what you could pay
*Please note that this amount will **not** be billed in a lump sum, but at the listed rate per session outlined in the Informed Consent and sent to you monthly.

The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $140. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Your total estimated charges will increase/decrease according to the number of visits and length of treatment.

Out-of-network provider: Jess Albright, LCPC, ACS

Service Code	Description	Number of Weeks	Total estimated charges for 1 session per week
90834	Individual Therapy	1 Week of Service	$140
		4 Weeks of Service (Approx. 1 Month)	$560
		8 Weeks of Service (Approx. 3 months)	$1,120
		39 Weeks of Service (Approx. 9 months)	$5,460
		52 Weeks of Service (Approx. 12 Months)	$7,280

►**Please note that this estimate does not include other unexpected fees that could arise.** Please review Informed Consent for fees associated with no shows, late cancellations, paperwork requests, and telephone consultation time (outside of normally scheduled appointment time).

►**Questions about this notice and estimate?** Call Jess Albright, LCPC, ACS at (240) 457-9015 for further questions.

If you are billed for at least $400 more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact Jess Albright, LCPC, ACS to let me know the billed charges are higher than the Good Faith Estimate. You can ask us 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 Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.

With my signature, I am saying that I agree to receive services from Jess Albright, LCPC, ACS at the listed rate per session, and I waive my right to have services submitted through my health insurance plan. I acknowledge that, if desired, I can still submit superbills of services to my health insurance for potential reimbursement after the full fee has been paid upfront to Jess Albright, LCPC, ACS. I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I was given a written notice explaining that my provider is not in my health insurance plan's network. I was also given the estimated cost of services, and what I may owe over time if I agree to be treated by this provider.
- I have been provided information on my right to dispute a bill if it is higher than the Good Faith Estimate.
- I have been notified that I have the option of seeking in-network services with my health insurance plan.
- I fully and completely understand that the amounts I pay may not count towards my health insurance plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider in writing before receiving services.

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Clinician Signature: _____ Date: _____

Clinician Printed Name: _____ Date: _____