Rachelle Bloksberg, LMFT #119841

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name Zoe Moshenberg	Middle Name	Last Name
Patient Date of Birth: 07/10/1993		
Patient Identification Number: Not Applicable		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box 530 Greenbriar Circle		Apartment D
City Petaluma, CA 94954	State	ZIP Code
Phone (443) 717-1574		
Email Address zmoshenberg@gmail.com		
Patient's Contact Preference: [ ] By mail [X] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled Individual Psychotherapy		
Patient Primary Diagnosis Adjustment disorder with mixed anxiety and depressed mood		Primary Diagnosis Code F43.23
Patient Secondary Diagnosis		Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Service or Item will be provided:
3/03/2022

[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: 2/26/2022

Summary of Expected Charges
(See the itemized estimate attached for more detail.)

Provider Name	Estimated Total Cost
Rachelle Bloksberg	$150 per session
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost

Total Estimated Cost: $ $150

The following is a detailed list of expected charges for psychotherapy. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Rachelle Bloksberg, LMFT Estimate

Provider/Facility Name	Rachelle Bloksberg, LMFT #119841			Provider/Facility Type	Private Practice
Street Address	578 Sutton Way, #377				
City	Grass Valley	State	CA	ZIP Code	95945
Contact Person	Rachelle Bloksberg	Phone	(530) 263-1413	Email	Rachelle@RachelleBloksberg.com
National Provider Identifier	1326348558			Taxpayer Identification Number	87-4214748

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Psychotherapy/ Counseling	Online	F43.23	90834	1	$150

Total Expected Charges $	150
Additional Health Care Provider/Facility Notes	

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.

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

You may contact the health care provider or facility 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.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

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.