



TRANSCENDENT SANCTUARY

Individualized Good Faith Estimate Template | Uninsured / Self-Pay

Notice to Patients: This template is an illustrative sample format intended for completion by the practice before delivery to an uninsured or self-pay patient. It is not a final estimate until individualized, dated, and reviewed for legal compliance. Eligible uninsured or self-pay clients receive an individualized Good Faith Estimate based on reasonably expected services and charges.

Patient & Convening Provider Information

Patient Name: _____

Date of Birth: _____

Patient Mailing Address: _____

Phone / Email: _____

Expected Service Period: _____

Estimate Date: _____

Convening Provider: Transcendent Sanctuary / Kimberly Trickey, MS, LPC

Practice Phone: [On File]

Provider NPI: _____

Tax ID: _____

Diagnosis / Reason for Care (if known): _____

Expected Psychotherapy Services & Itemized Estimate

Service / Description	Code (if known)	Qty	Unit Fee	Estimated Total
Individual preparation (60 min)	[]	1	\$195	\$195
Individual dosing (3 hr)	[]	2	\$550	\$1,100
Individual integration (60 min)	[]	2	\$195	\$390
Additional services (specify)	[]	0	[]	\$0
In-home travel (if applicable)	N/A	0	\$100/hr	\$0
TOTAL — psychotherapy only				\$1,685

Example above assumes 1 preparation, 2 three-hour dosing, and 2 integration sessions. Adjusted to the individual's reasonably expected care; no particular treatment course is guaranteed.

Separate Journey Clinical Charges — Informational Only

Separate Medical/Prescribing Service	Illustrative Planning Amount
Initial medical evaluation	\$250
Initial medication (up to 2 sessions)	\$112
Illustrative separate Journey Clinical subtotal	\$362

Journey Clinical is an independent medical provider. Its fees are not included in Transcendent Sanctuary's psychotherapy total. The medical provider must furnish its own applicable estimate or billing information. Verify all medical and pharmacy prices directly with Journey Clinical.

Required Estimate Disclosures (No Surprises Act)

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known when created and is not a contract or a guarantee of final charges. Actual services and charges may differ if care changes.

Patient Dispute Rights: You may dispute a bill if it is at least \$400 more than the Good Faith Estimate for a provider or facility. You can ask the provider to update the bill, negotiate, or initiate the federal patient-provider dispute resolution process within the applicable deadline. Learn more at www.cms.gov/nosurprises or call 1-800-985-3059. Keep a copy of this estimate.

Acknowledgment of Receipt (Optional / Practice File)

Patient Signature: _____

Date: _____

Prepared by: Kimberly Trickey, MS, LPC

Date: _____