Good Faith Estimate

Provided under the No Surprises Act to uninsured and self-pay clients.

ADE, Inc.
Martha H. Ireland, PhD, RN, CS
165 Topside E.
Hardeeville, SC 29927
(703) 722-2324 | info@irelandphd.com

> *This is an estimate, not a bill and not a contract. It reflects what Dr. Ireland reasonably expects your care to cost based on what is known today. Your actual care may be more or less than estimated depending on how treatment goes, and you are free to stop at any time.*

YOUR RIGHT TO A GOOD FAITH ESTIMATE

You have the right to receive a Good Faith Estimate explaining how much your medical and mental health care will cost. Under the law, health care providers must give clients who do not have insurance, or who are not using insurance, an estimate of the expected charges for services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency services.
- Make sure your provider gives you a Good Faith Estimate in writing at least one business day before your service. You can also ask for one before you schedule.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Keep a copy of your Good Faith Estimate in a safe place. You may need it if you dispute a bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

CLIENT INFORMATION

CLIENT NAME | DATE OF BIRTH | DATE OF THIS ESTIMATE

CLIENT ADDRESS | CITY | STATE | ZIP

LOCATION WHERE SERVICES WILL BE PROVIDED | ANTICIPATED START DATE OF CARE

PROVIDER INFORMATION

Provider	**Martha H. Ireland, PhD, RN, CS**
Practice	**Altering Disordered Eating, Inc. (ADE, Inc.)**
Address	**165 Topside E., Hardeeville, SC 29927**
Phone and email	**(703) 722-2324 | info@irelandphd.com**
Individual NPI	**1508448820**
Organizational NPI	**1891904900**
Federal Tax ID (EIN)	**51-0337897**
SC Business License	**BL26-000094**

EXPECTED DIAGNOSIS

PRIMARY DIAGNOSIS, IF ESTABLISHED | DIAGNOSIS CODE | ADDITIONAL DIAGNOSES

A diagnosis may not be established until after the initial evaluation. If that is the case, this estimate reflects expected services rather than a confirmed diagnosis, and a revised estimate can be issued once treatment planning is complete.

ITEMIZED ESTIMATE OF EXPECTED SERVICES

SERVICE	CPT CODE	RATE	EXPECTED NUMBER	ESTIMATED TOTAL

ESTIMATED TOTAL FOR THE PERIOD COVERED

PERIOD COVERED BY THIS ESTIMATE

Service Codes and Rates Used by This Practice

90791 Diagnostic evaluation, first visit	**$295**
90837 Psychotherapy, 53 minutes or longer	**$195**
90834 Psychotherapy, 38 to 52 minutes	**$195**
Time beyond 50 minutes, clinical calls, email, and written reports	**$3.90 per minute**

Telehealth Claim Format

If you submit this estimate or a statement to your own insurance company for out-of-network reimbursement, a telehealth session is coded as follows.

Procedure code, standard 53 to 60 minute video session	**90837**
Modifier, synchronous audio and video	**95**
Place of service, client located in their home	**10**

Place of service 10 applies when the client is in their home, which includes a permanent residence, a hotel, or temporary lodging. A different place of service code applies if the client attends from another location.

HOW THIS ESTIMATE WAS BUILT

Frequency and duration of therapy are clinical judgments, and they change. This estimate assumes a course of treatment discussed with you at the outset. If Dr. Ireland recommends more or fewer sessions than estimated, she will tell you and, where the change is significant, issue a revised Good Faith Estimate.

ASSUMPTIONS USED IN THIS ESTIMATE: EXPECTED SESSION FREQUENCY, ANTICIPATED LENGTH OF TREATMENT, AND ANY SERVICES NOT INCLUDED

WHAT IS NOT INCLUDED

- Services provided by anyone other than Dr. Ireland, including physicians, dietitians, laboratories, psychiatric prescribers, and higher levels of care. Those providers must give you their own Good Faith Estimate.
- Charges for late cancellations and missed appointments, which depend on your attendance.
- Clinical phone calls, email, and written reports, which are billed by the minute as used.
- Emergency services.

ACKNOWLEDGMENT

I have received this Good Faith Estimate. I understand it is an estimate of expected charges, that it does not obligate me to any particular course of treatment, and that my actual costs may differ.

CLIENT, PARENT, OR GUARDIAN SIGNATURE

DATE

PROVIDER SIGNATURE

DATE

PRINTED NAME

METHOD OF DELIVERY TO CLIENT (SECURE EMAIL OR MAIL)