**GOOD FAITH ESTIMATE**

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| Client Name: | Date of Birth: |
| Address: | |
| Patient Diagnosis (if applicable): | |
| Services Requested: | Date of Estimate: |
| Date of Initial Session: |

You are entitled to receive this Good Faith Estimate by Law. The charges listed below represent the current costs for psychotherapy services. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for any given person, this form provides a basic 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 services recommended or requested separately, as part of your care, that may not be reflected in this good faith estimate and will be discussed prior to services being rendered. **NOTE**: This estimate is not a contract, you are under no obligation to continue services.

**Session Fees (in-person or via telehealth)**

Standard Psychotherapy session, 45-60mins - $175.00 Extended session up to 75mins - $200.00 Joint/ family/couple session up to 90mins - $225.00

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| Ex: $175.00 x 8 weekly sessions = $1400.00 | 175.00 x 20 biweekly sessions = $3500.00 |

A Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and your desired goals, as discussed during the initial consultation. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time, for any reason. Please feel free to ask any clarifying questions you may have regarding your treatment plan, or the information provided in this Good Faith Estimate.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059](https://www.cms.gov/nosurprises/consumers%20or%20call%201-%20800-985-3059). The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.