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GOOD FAITH ESTIMATE

As required by the federal No Surprises Act, here is your Good Faith Estimate for services received at our clinic this year.

I, _____, understand that my psychotherapist,

_____, may provide the following services for me this year:

_____ Individual Psychotherapy at $125 per 60-minute session

_____ Group Psychotherapy at $260 per month for five months, four weekly sessions per month, 150-180 minutes per session: a total of $1,300 for 20 group sessions

_____ Other services: _____

_____

Mental health diagnosis(es) for which I am being provided services: _____

_____

Estimate of frequency, duration and total cost of individual treatment: I understand that, for individual psychotherapy, I myself determine, in consultation with my psychotherapist, the frequency and total number of sessions that I utilize, and thereby the total costs I incur. I may cease receiving individual psychotherapy services at any time I choose without further charges if I give my psychotherapist at least 24 hours notice before the next scheduled session. It is recommended but not required that I attend one further session before termination in order to discuss and reinforce what I have learned and the progress I have made, and to discuss strategies to continue making progress on my own and to prevent relapse.

I further understand that, for individual psychotherapy, I will be charged for one full session if I do not attend a scheduled session, or if I cancel a session or terminate services with less than 24 hours of notice. I understand that my insurance company will not reimburse me for no shows and late cancellations.

Estimate of frequency, duration and total cost of group treatment: I understand that, for group psychotherapy, I am committing financially to the entire 5-month group: 20 weekly sessions, $260 per month, $1,300 total. I understand that, if I cease attending the group before it is over, I will be required to pay for the remainder of the group sessions for which I have committed since no one else can take my slot after the group has begun. I understand that my monthly fee for group sessions remains the same even when I do not attend every session in a month.

Fee payment and insurance submission: I understand that my fees are due in full at each individual psychotherapy session, or by the first session of each month for group psychotherapy, and that there is a $10 additional fee for any payment I make that is more than 7 days late. If I so request, my psychotherapist will provide me a Statement of Services document for me to submit to my health insurance so that I may seek reimbursement. I further understand that my insurance may not cover all of the fees charged by my psychotherapist, and that it is my own responsibility to determine what is covered and what is not.

Disputes: I understand that, if I have a dispute or questions about this Good Faith Estimate or about my rights, I am encouraged to discuss these concerns with my psychotherapist, and/or to contact the US Department of Health and Human Services: 800-985-3059; **www.cms.gov/nosurprises**.

_____	_____	_____
Client name, printed	Client signature	Date
_____	_____	_____
Psychotherapist name, printed	Psychotherapist signature	Date