CENTER FOR MINDFUL PSYCHOTHERAPY

GOOD FAITH ESTIMATE (GFE) of Psychotherapy Services

Rendering Provider:
<Your Name>, Associate Marriage & Family Therapist (AMFT), #XXXXXX
Individual NPI: XXXXXXXXXX
Work Phone: (XXX) XXX-XXXX
Supervised By: <Supervisor Name>, LMFT #XXXXXX

Agency Provider:
Center for Mindful Psychotherapy (CMP)
533A Castro Street, San Francisco, CA 94114
Tax ID: 463448762 / NPI: 1154759157

Client Name:
Client Address:
Client Phone #:
Client DOB:
Client Diagnosis Code *(if known/applicable, i.e. F41.1, or "TBD")*:
Client Service Code *(i.e. 90834)*:

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an 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. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment nor 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 what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

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The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $_____.

Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

Based upon a fee of $_____ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $_____for four visits provided over the course of one month; $_____for eight visits over two months; or $_____for 12 visits over three months.

If you attend therapy for a longer period, your total estimated charges will proportionally reflect the number of visits and length of treatment as stated above.

You have a 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).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted 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.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above.

_____

Client Signature

Date: _____