# GOOD FAITH ESTIMATE
# TABLE OF SERVICES AND FEES

Client: _____

| Service code (CPT Code) | Description | Fee for Service (Number of Sessions Will Be Determined as We Progress) |
|---|---|---|
| 90832 | Psychotherapy, 30 minutes | $120 |
| 90834 | Psychotherapy, 45 minutes | $180 |
| 90837 | Psychotherapy, 60 minutes | $240 |
| 90846 | Conjoint or Family Psychotherapy without Patient Present, 45 minutes | $180 |
| 90847 | Conjoint or Family Psychotherapy with Patient Present, 45 minutes | $180 |
| 98966-98968 | Telephone Assessment & Management | Prorated based on the amount of time spent at hourly rate |
| Cancelation Fee | **Dr. Stone Requires a 24-Hour Cancelation Fee** | ***You are Responsible for the Fee of the Appointment Missed** |
| Production of Records | | Prorated based on the amount of time spent at hourly rate |
| Legal Fees | | Prorated based on the amount of time spent at hourly rate |
| Total Estimate: | This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your diagnosis and presenting clinical concerns. | |

## GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider has gone over this Good Faith Estimate with you, and any questions or concerns have been addressed.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date of signature