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	$135
90834	Psychotherapy, 45 minutes	$195
90837	Psychotherapy, 60 minutes	$260
90846	Conjoint or Family Psychotherapy without Patient Present, 45 minutes	$195
90847	Conjoint or Family Psychotherapy with Patient Present, 45 minutes	$195
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