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# Good Faith Estimate – Counseling Intern

Name:_____ Date of Birth:_____

You have been referred to our office for treatment or sought treatment on your own. I'm required by the 2022 No Surprises Act to give you a Good Faith Estimate of the cost of because we do not accept payment from insurance for this care. Since we haven't met, and don't yet know if you want to use insurance, via Superbill, for your treatment, the information below is based on "fee for service" (out of pocket) rates.

If you DO intend to use insurance by turning in a Superbill to your insurance company, check with your insurance carrier to find out what your reimbursement rates will be–they are likely to be much smaller.

Since I have not yet evaluated your difficulties or symptoms, I must at this point estimate your course of treatment based upon the national average for a course of psychotherapy, which is 18 encounters.

This initial estimate is valid for 12 months, but you are entitled to receive an update on this estimate at any time upon request.

**Current ICD-10 diagnosis:** R69 (diagnosis deferred) OR _____
**Anticipated treatment:**

- 1 session of CPT 90791 (diagnostic evaluation) at $50 OR $_____
- 17 weekly sessions of CPT 90837 (psychotherapy, 60 minutes) at $25 per session, OR $_____
- Total of estimated "fee for services" treatment without insurance: $475 OR $_____

*This is just a rough estimate based on national averages.* The duration of our work together can be longer or shorter depending upon your symptoms, your work between sessions, and your response to treatment.

Unless required by a court order (an extremely rare situation), you are free to discontinue treatment at any time, and free to discuss any other modifications to treatment modalities, frequency, or duration. You are ultimately in control of your own mental healthcare; I am just here to provide help at your request.

**Location of treatment:** All sessions will take place in one of my three offices listed in the header.

**My identifying information:**

_____
*Clinician Name & Credentials*

**National Provider Identifier:** 1235750324
**Tax ID number:** 84-4235016

By signing this Good Faith Estimate, I understand and agree to the above information and conditions. I also understand that there will be at least one discussion regarding the therapeutic need and costs of services before the 18th session and this estimate may be revised and updated.

_____ _____
Client Signature (Or Parent/Legal Guardian) Date

_____ _____
Client Signature (Or Parent/Legal Guardian) Date

_____ _____
Clinician Name/Credentials Date