**GOOD FAITH ESTIMATE**

**TABLE OF SERVICES AND FEES**

Client Name: This applies to all standard therapy clients and not sliding fee scale clients

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| --- | --- | --- | --- |
| **Date of****Service (If Known)** | **Service code****(CPT Code)** | **Description** | **Fee for Service (Number of Sessions Will Be Determined as We Progress)** |
|  | 90791 | Initial Diagnostic Evaluation | $150 |
|  | 90832 | Psychotherapy, 16-37 minutes | N/A |
|  | 90834 | Psychotherapy, 38-52 minutes | N/A |
|  | 90837 | Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated) | $150 |
|  | 90839 | Psychotherapy for a Crisis (30-74 minutes) | Prorated per hourly rate |
|  | 96150 | Third Party Donor Recipient Consultation | $300 |
|  | 90846 | Family Psychotherapy without Patient Present, 50 minutes | $150 |
|  | 90847 | Family Psychotherapy with Patient Present, 50 minutes | $150 |
|  | 96152 | Third party Donor Consult for single intended parent | $250 |
|  | 98966-98968 | Telephone Assessment & Management | Prorated based on the amount of time spent at hourly rate |
|  | 98970-98972 | Online Digital Evaluation & Mgt(Responding to Email & Text Messages) | Prorated based on the amount of time spent at hourly rate |
|  | Cancelation Fee  | Your Therapist Requires a 24-Hour Cancelation Fee  | You are Responsible for the Fee of the Appointment Missed |
|  | Production of Records |  | TBD |
|  | Legal Fees |  | TBD |
|  |
|  | 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 and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.  |
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Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identica