Therapist Name
Sugarloaf Counseling and Psychotherapy Associates
18 Executive Park Court
Germantown, MD 20874
301-428-3557
Therapist Name@sugarloafcounseling.com

Good Faith Estimate

Client Name_____

Date of Birth_____

Type of Services Provided_____

Diagnosis and Treatment Codes _____

Estimated Length of Services Provided_____

Locations of Client and Therapist _____

_____

Description of Treatment Modality(ies) Used_____

Treatment Goals_____

Estimated Charges for each Service Provided_____

STATEMENT AND DISCLAIMER: If you are uninsured or insured but self-pay, you have the right to receive a Good Faith Estimate (GFE) for services. These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length or cost. If estimates or services are added or changed, you will receive a new GFE. Your signature does not create a contract or require you to receive psychotherapy services from me. If actual costs of services greatly exceed the estimate (by $400 or more), you may initiate dispute resolution (DR) by contacting HHS within 120 days at www.cms.gov/nosurprises or at 1-800-985-3059. Initiating DR will not adversely affect your quality of care. Additional services must be scheduled or requested separately. A copy of this document was provided (check one) ___ in person ___ online _____ Email _____US mail

Therapist Signature_____ (Printed)_____DATE _____

Client Signature_____ (Printed)_____ DATE _____

If Client is a minor, parent/guardian signs here:

Parent/Guardian Signature _____(Printed)_____

DATE_____