**INFORMED CONSENT AGREEMENT**
**COUNSELING SERVICES**

Patient Name: _____ Fee: $_____

This document contains important information about our professional counseling services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. We can discuss any questions you have prior to any therapeutic services being rendered or at any time in the future.

## PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client/patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Each of our therapists also has corresponding responsibilities to you. These rights and responsibilities are described herein.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, grief, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has scientifically been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are *no guarantees* about what will happen or what results will be gained. Psychotherapy requires a very active effort on your part! In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with us. If you have questions about any of our procedures or recommendations, we should discuss them whenever they arise.

## APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, several times per month, at a time that we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with at least 24 hours' notice. ***If you miss a***

***session without cancelling or cancel with less than 24 hours' notice, you are agreeing to pay the full fee for that time (unless we both agree that you were unable to attend due to circumstances that were beyond your control)***. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the standard fee as described above. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your sessions on time. If you are late, your appointment will still need to end at the predetermined scheduled time.

**PROFESSIONAL FEES**

The standard fee for the initial intake is $250.00 and each subsequent session is $175.00. You are responsible for paying at the time of your session unless prior arrangements and billing agreements have been made. Payments may be made by credit, checks or cash. Any checks returned are subject to an additional $25.00 fee to cover the bank fees the will incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency in the future to secure payment.

In addition, to weekly appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly costs) for other professional services that you may require or request such as report writing, telephone or teleconferencing conversations that last longer than 15 minutes, attendance at meetings or consultations, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that we discuss this fully before you waive your right to confidentially. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify or participate in any proceedings.

**INSURANCE**

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing services will assist you to the extent possible in filing claims and ascertaining information about your coverage (if applicable), but you are responsible for knowing your coverage and for letting us know if/when your coverage changes. Furthermore, you agree that in consideration of treatment services to be rendered, you will make timely payments in accordance to the following:

a. **Insurance Billing:** Services will be billed at the negotiated rate agreed upon between STILLPOINT FAMILY COUNLSELING SERVICES and Patient's insurance carrier. It is the responsibility of the patient to provide the current insurance information to STILLPOINT FAMILY COUNLSELING SERVICES (set forth in Exhibit A) in order to allow STILLPOINT FAMILY COUNLSELING SERVICES to obtain proper insurance coverage information as well as referrals and authorizations.
b. **Private Billing:** In the event you agree to pay STILLPOINT FAMILY COUNLSELING SERVICES privately for treatment, you will be billed based on our standard rates for services and timely payments must be made in accordance to the rates set forth on the ***Good Faith Estimate*** form in Exhibit D.

You should also be aware that most insurance companies require you to authorize STILLPOINT FAMILY COUNLSELING SERVICES to provide them with a clinical diagnosis (diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term in nature. All diagnoses come from the diagnostic manual entitled the DSM-V). Sometimes, we have to provide additional clinical information such as treatment plans or summaries, or copies of the patients entire clinical record (this is rare). This information will become part of the insurance company files and will probably be stored in their computer system. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is requested and received. We will provide you a copy of any report or summary we submit, if you requested in writing. By signing this agreement, you agree that STILLPOINT FAMILY COUNLSELING SERVICES can provide the requested information to you carrier if you plan to use insurance funding to pay for treatment.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. ***If you did not obtain authorization and it is required, you may be responsible for full payment of the fee.*** Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as co-payment) to be covered by the patient. Either amount is to be billed or payed to STILLPOINT FAMILY COUNLSELING SERVICES by the due date listed on your invoices. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met. It is important to note, that many deductible amounts may also need to be met at the start of each calendar year, meaning that new deductibles start January 1st of each new year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions***. It is important to remember that you always have the right to pay for services yourself to avoid problems described above, unless prohibited by a provider contract.***

If we are not a participating provider for your insurance plan, we can supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement upon request. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, you can refer to your insurance customer service coordinator and they can refer you to in-network providers.

**PROFESSIONAL RECORDS**

We are required by law to keep appropriate records of the psychological services we provide. Your records are maintained in a secure location in each STILLPOINT FAMILY COUNLSELING SERVICES office. We keep brief records noting that you were present, your reasons for seeking therapy services, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social and treatment history, records we receive from other providers, copies of records we sent to others, and your billing records.

## CONFIDENTIALITY

Policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Please note, California law and professional ethics require mental health professionals to maintain the utmost confidentiality of their patient's records and information ***EXCEPT*** for:

***1. Child Abuse Reporting***
***2. Elder Abuse Reporting***
***3. You, the patient, is in danger of hurting yourself***
***4. You have made a threat of violence against another that triggers a duty to warn (CA Civil Code Section 43.92)***
***5. You have pursued civil litigation and waived your rights by tendering your emotional condition***
***6. You shield the planning of a crime or tort (CA Evidence Code Section 1018)***

Patients being seen in couple, family and group work are obliged ethically and legally to respect the confidentiality of others and the therapist will exercise discretion (but not absolute confidentiality) when disclosing private information to other participates in the treatment process. We may at any time seek out consultation with our colleagues without permission but your identity will be kept confidential.

## PATIENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under the age of 13 unless they agree that we can share whatever information we consider necessary with a parent. For children 13 and older, we request an agreement between the patient and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless we feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

## TELEHEALTH SERVICES

The Health Resources Services Administration defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine. While telemedicine refers specifically to remote clinical services,

telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

If you are in a situation that does not allow you to participate in local services, telehealth services can be provided to you from a fully licensed mental health professional.

*Expected Benefits:*

1. Immediate access to STILLPOINT FAMILY COUNLSELING SERVICES counseling services that will pair you with a STILLPOINT FAMILY COUNLSELING SERVICES counselor that is a fully licensed mental health professional.

2. More efficient and immediate case evaluation and management

3. Obtaining expertise from a counselor that may help you attain services locally

4. Can receive care and counseling from the comforts of your own home

5. Decreases commuting times and increases availability for treatment

*Possible Risks:*

While its advantages are many, there are a few risks, including:

1. *Equipment breakdowns*: Telemedicine hinges on the smooth operation of equipment like computers, web cameras, internet services, WiFi reception and appropriate software. Inoperable equipment, technology or software spurs more than business interruption risks at healthcare facilities. Patient safety and health are at stake if clinicians receive, pass along or act upon inaccurate information, or cannot facilitate adequate or continuous care because of faulty technology or equipment.

2. *Security and privacy breaches*: The security and privacy of sensitive patient information is an urgent risk for any healthcare institution, but especially for those facilities heavily vested in telemedicine services. For example, the constant transmission of patient records or treatment over wireless networks is susceptible to hacking and other security breaches; and patient records or sessions are potentially accessible to more people than medical staff because IT teams are involved with the maintenance and operations of telemedicine networks.

3. *Credentialing and licensing issues*: Liability issues could arise, diagnosis errors in particular, if its telemedicine provider's practitioners—operating in another state or country—don't have the appropriate credentials or licenses, or don't adequately meet their governing board's conditions for telehealth treatment. Facilities might also be exposed to providers allowing practitioners to perform certain duties or offer care or diagnoses outside their scope of certification or licensure. ***-All of STILLPOINT FAMILY COUNLSELING SERVICES are licensed mental health professionals (Marriage and Family Therapists) that reside in California and will only provide telehealth sessions from a confidential, office environment. To verify your therapist's license and credentials, please visit: https://search.dca.ca.gov/***

4. *Informed consent mismanagement*: Without comprehensive informed consent policies and procedures, patients may not realize the risks or advantages of telemedicine—or even that they might be receiving such care. Neglecting to adequately explain specific telemedicine services and how they might be used for a patient's treatment, or neglecting to obtain consent for such services, could become a major matter of negligence if not discussed with their patients prior to treatment services.

***Though there are inherent risks to telehealth treatment, STILLPOINT FAMILY COUNLSELING SERVICES takes every precaution and protection to assure each patient that their care and treatment is upheld by the highest standards set forth by state laws and ethical guidelines provided by the licensing agencies.***

**CONTACTING YOUR COUNSELOR**

We are not often immediately available by telephone and email. If we are not available by telephone, you may leave a message on our confidential voicemail system or send us a confidential email and your call/email will be returned as soon as possible, but it may take up to three days for non-urgent matters. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call/email or if you feel unable to keep yourself safe:

1. Contact the personal emergency number that ***may be*** given to you by your counselor
2. Contact your Community Mental Health Services and/or 988 for the Suicide & Crisis Hotline
3. Call 911 and ask to speak to the mental health worker on call.
4. Go to your local hospital emergency room for care and assistance

We will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the covering mental health professional.

**TERMINATION OF TREATMENT**

STILLPOINT FAMILY COUNLSELING SERVICES may terminate treatment if payment is not timely, if recommendations are not followed (such as seeking consultations from specialists, refraining from dangerous practices, coming to sessions sober and alert, etc.), or if some problem emerges that is not within the scope of practice or competency of the counselor. The usual minimal termination period is 2 weeks. You are urged to consider the risk which major psychological transformation may have on current relationships and the possible need of psychiatric consultations during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. ***Patients have the right to refuse or to discontinue services at any time***.

If you are unhappy with what is happening in therapy, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken very seriously and handled with the utmost care and respect. You may also request that we refer you to another therapist within our agency or an external referral to a therapist in your area. You have the right to considerate, safe

and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of therapy and about our specific training and experience. You also have the right to expect that we will not have any social or sexual relationships with current patients or with former patients. ***The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapy. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.***

> ***NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT IN ITS ENTIRITY AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. PLEASE DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH IMPAIR YOUR MENTAL ABLITIES AND ABLITIES TO MAKE JUDGMENTS OR IF YOU FEEL RUSHED OR UNDER PRESSURE***.

Patient acknowledges that they have read, discussed, understands, and agrees to the above terms of this Informed Consent Agreement, as well as the Exhibits to this Agreement (including Exhibit A, Exhibit B, Exhibit C, Exhibit D, and the attachments thereto), and that Patient has been able to ask STILLPOINT FAMILY COUNLSELING SERVICES and their physician, psychologist or other healthcare professional any questions regarding the therapy and services to be provided by STILLPOINT FAMILY COUNLSELING SERVICES.

Signature: _____ Patient/Guardian Name: _____
Date: _____

Signature: _____ Patient/Guardian Name: _____
Date: _____

_____
Authorized STILLPOINT FAMILY COUNLSELING SERVICES Representative (name, title)

Executed this _____ day of _____, 20__, in the State of California.

**EXHIBIT A**

**COORDINATION OF INSURANCE COVERAGE STATEMENT (Page 1 of 3)**

***Today's Date:*** _____

***Patient's Name:*** _____ ***Date of Birth:*** _____

*(month) / (date) / (year)*

_____

☐ **The above-named Patient has the following up to date insurance coverage:**

**PRIMARY INSURANCE (copy of insurance cards are required for all insurance coverage)**

| | |
|---|---|
| Primary Insurance Holder Name: | |
| Primary Insurance Holder Birth Date: | |
| Relationship to patient: | |
| Name of Insurance Carrier: | |
| Carrier Address: | |
| Covered Dependents: | |
| Policy Number: | |
| Policy Effective Date: | |
| *Primary Insurance Holder Signature:* | |

## COORDINATION OF INSURANCE COVERAGE STATEMENT (Page 2 of 3)

**SECONDARY INSURANCE**

☐ Not Applicable

| | |
|---|---|
| Secondary Insurance Holder Name: | |
| Secondary Insurance Holder Birth Date: | |
| Relationship to patient: | |
| Name of Insurance Carrier: | |
| Carrier Address: | |
| Covered Dependents: | |
| Policy Number: | |
| Policy Effective Date: | |
| *Secondary Insurance Holder Signature:* | |

☐ **The above-name patient already has correct insurance information already on file.**

Primary Insurance Holder Name: _____

Signature: _____

Secondary Insurance Holder Name: _____

Signature: _____

☐ **The above-name patient DOES NOT have insurance coverage.**

Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

## COORDINATION OF INSURANCE COVERAGE STATEMENT (Page 3 of 3)

**Today's Date:**

**Patient Name:** _____ **Date of Birth:** _____

(month) / (date) / (year)

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE PROVIDED INSURANCE COMPANY BE MADE DIRECTLY TO STILLPOINT FAMILY COUNLSELING SERVICES AND ANY REPRESENTATIVE FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE OR OTHER FUNDING SOURCES, INCLUDING DEDUCTIBLES AND COPAYMENTS.** I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NONPAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND OR/COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

*While STILLPOINT FAMILY COUNLSELING SERVICES will endeavor to prepare accurate and timely billings on my behalf to my insurance company, I agree that I am financially responsible to pay STILLPOINT FAMILY COUNLSELING SERVICES for any and all deductibles, coinsurance and/or co-payments that are my financial responsibility under my insurance plan, as well as any amounts that exceed the benefit maximums of my plan (if any).*

*Co-payments, coinsurance, and/or deductibles may be billed to me as an estimate in advance of my insurance company payment, and if necessary will be adjusted and billed or credited to me after my insurance company makes payment to STILLPOINT FAMILY COUNLSELING SERVICES.*

*Although STILLPOINT FAMILY COUNLSELING SERVICES will attempt to obtain accurate information regarding my eligibility and benefits, STILLPOINT FAMILY COUNLSELING SERVICES makes no promises or assurances of benefits payment. I will be responsible for required payments as a result of a change in benefits after this date as well as incorrect benefit information given to STILLPOINT FAMILY COUNLSELING SERVICES by my carrier. In addition, I will inform STILLPOINT FAMILY COUNLSELING SERVICES immediately in the event that my coverage is terminated or changed.*

*I understand that a Regional Center or other funding source may or may not accept responsibility for my co-payment and/or co-insurance. In the event that there is any outstanding balance to my co-payment, co-insurance, and/or deductible, I understand that I am responsible for the full amount of the remaining balance.*

**Primary Insurance Holder / Legal Guardian:** _____

**Signature:** _____

**Secondary Insurance Holder/**
**Legal Guardian (if *applicable):*** _____

**Signature:** _____

**EXHIBIT B**

**CONSENT FOR RELEASE OF INFORMATION**
**AUTHORIZATION TO DISCLOSE PARTICIPANT HEALTH INFORMATION (PHI)**
HIPAA Form 3.601

***Date:*** _____

| | | |
|---|---|---|
| **Patient Name:** | | **Date of Birth:** |
| **Authorized Rep. or Guardian:** | | **Relationship:** |
| **Email:** | **Phone:** | **Service Office:** |
| **Address:** | | |

**As required by HIPAA Privacy Regulations & applicable portions of the California Welfare and Institutions Code Section 4514, protected health information may not be used or disclosed to a third party without participant authorization.**

- I hereby consent to, request, and authorize STILLPOINT FAMILY COUNSELING SERVICES and their representatives. to **receive** any or all funding-related, medical, social, psychological, or educational information regarding the above-named participant/patient **from** (**Funding Agency** and/or Individual) _____ with the understanding that all such information becomes part of the STILLPOINT COUNSELING ASSOCIATES records and will be utilized for planning services for the above-named participant/patient.
- I hereby consent to, request, and authorize the STILLPOINT FAMILY COUNSELING SERVICES and their representatives to **release** any or all funding-related, medical, social, psychological, or educational information regarding the above-named participant/patient **to** (Funding Agency or Individual) _____.

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Effective date for this authorization: From _____To _____

### I understand I have the right to:

1. Revoke this Authorization by sending written notice to this office, except to the extent that: (1) STILLPOINT FAMILY COUNLSELING SERVICES has taken action in reliance on my prior authorization; or, (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Participant Health Information being used or disclosed under federal law.
4. Restrict what is disclosed with this authorization.
5. Receive a copy of this Authorization and understand that a photocopy is as valid as an original.
6. Inspect or copy any Protected Health Information being used or disclosed under federal law.
7. Refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (1) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization; (2) if/when I am receiving health care solely for the purpose of creating information for disclosure to a third party and then I may not receive care unless I sign the Authorization.
8. Be immediately informed of any remuneration involved due to any marketing or sale of my Protected Health Information (I understand that my Protected Health Information may not be used or disclosed in either such case without my express authorization to the same).

I have received a copy of this Authorization.

_____ _____

Signature of Participant or Authorized Representative / Guardian *Date:*

## EXHIBIT C
### REQUEST FOR ALTERNATIVE COMMUNICATIONS

**Date: _____**

| **Patient Name:** | | **Date of Birth:** |
|---|---|---|
| **Authorized Rep. or Guardian (if applicable):** | | **Relationship:** |
| **Email:** | **Phone:** | **Fax:** |

I understand that I may request to receive confidential communications by alternative means or at alternative addresses. We will accommodate all reasonable requests with this office to provide the following "Alternative" means of communicating Protected Health Information. Please fill out:

**Mailing Address** _____

**Home Phone Number** _____

**Cell Phone Number** _____

**Work Phone Number** _____

**Fax Number** _____

**E-Mail Address** _____

**Please contact me via:**

- □ Home Phone
- □ Work Phone
- □ Cell Phone (voice)
- □ Cell Phone (Text Message)
- □ Email
- □ U. S. Mail / Postcard

**Please do <u>not</u> contact me via**:

- □ Home Phone
- □ Work Phone
- □ Cell Phone (voice)
- □ Cell Phone (Text Message)
- □ Email
- □ U. S. Mail / Postcard

**Other instructions/restrictions (please specify): _____**.

_____ _____

Signature of Participant or Authorized Representative Date

**EXHIBIT D**

# GOOD FAITH ESTIMATE FORM

*(For Standard Clinical Fess of Services)*

| | |
|---|---|
| Patient Name: | Patient Date of Birth: |
| Patient Address (include if telehealth): | |
| Patient Diagnosis (if known/applicable): | |
| Services Requested: | Date of Initial Session (if applicable): |

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this good faith estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

The fee for a 50-60-minute psychotherapy visit (in person or via telehealth) is **$175**. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based on a fee of **$175** per visit, the following are expected charges of psychotherapy services:

| Number of Weeks | Total estimated charges for 1 session per week | Total estimated charges for 2 sessions per week |
|---|---|---|
| 1 Week of Service | $175 | $350 |
| 13 Weeks of Service (Approx. 3 Months) | $2,275 | $4,550 |
| 26 Weeks of Service (Approx. 6 months) | $4,550 | $9,100 |
| 39 Weeks of Service (Approx. 9 months) | $6,825 | $13,650 |
| 52 Weeks of Service (Approx. 12 Months) | $9,100 | $18,200 |

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Signature of Agreement/Understanding: _____

Date of this Estimate: _____