

## GOOD FAITH ESTIMATE

Provider Name: Sloan Gorman	License#: CA: LCSW 77773, CT: 005502
Provider Address: 205 Keller Street, Suit 202C, Petaluma CA 94952	
Provider Phone #: (707) 789-7894	
Provider Tax ID#: 85-0699715	Provider NPI #: 147766399666

Client Name:
Client Address:
Client Phone:
Client Email:
Client Diagnosis (if known/applicable):
Estimated Length of Service Provided: This will be determined by the Client and the Therapist based on the Clients needs and requests.

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.

This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services rendered to you that are not identified here.

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.

The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is \$160.00. 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 upon a fee of \$160 per visit, if you attend one psychotherapy visit per week, your estimated charge would be \$640 for four visits provided over the course of one month; \$1,280 for eight visits over two months; or \$1,920 for 12 visits over three months. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Calls between sessions, consultation, coordination of services, legal requests and/or reports are billed at the rate of individual sessions rate of \$160 (to be billed on a prorated basis).

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

Superbills and/or receipt of services will always be provided to the client upon request at no additional fee. I provide superbills on a monthly basis. The client is responsible for managing their own out-of-network or health savings accounts benefits.

Disclaimer: These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length or cost. Your signature does not require you to receive psychotherapy services from me.

Client Signature: \_\_\_\_\_

Date of this Estimate: \_\_\_\_\_