



Darci Stephenson

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EIN: 87-4159351

Good Faith Estimate

Patient Name _____ Date of Birth _____

Type of Services Provided _____

Diagnosis and Treatment Codes _____

Estimated Length of Services Provided _____

Locations of Patient 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, you may initiate dispute resolution (DR) by contacting HHS within 120 days. 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. ☐ US mail ☐ other _____

LPC Signature _____ LPC(Printed) _____ DATE _____

Patient Signature _____ Patient (Printed) _____ DATE _____

Rep. Signature _____ Rep (Printed) _____ DATE _____