Transcend Therapy, Inc.

GOOD FAITH ESTIMATE

Provider Name: Text	License/#: Text
Provider Address: 4452 Park Blvd, Suite 204, San Diego, CA 92116 7183 Navajo Rd., Suite B, San Diego, CA 92119	
Provider Phone #: ( )	
Provider Tax ID#: 30-0971791	Provider NPI #:Text

Patient Name:	Patient Date of Birth:
Patient Address (include if telehealth):	
Date of Initial Session (if applicable):	
Services Requested:	Patient Diagnosis (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 60-minute psychotherapy visit (in-person or via telehealth) is $________. 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 $_______ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $_____ for 4 visits provided over the course of one month; $________for 8 visits over two months; or $_________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.

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.

Date of this Estimate ______________________

Patient Signature _________________________