Jeremy Frank and Associates

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Good Faith Estimate for Health Care Items and Services

This Good Faith Estimate shows the costs of items and services you are reasonably expected to receive for outpatient psychotherapy. The estimate is based on known information at the time it was created. It is not a bill, and actual services and costs may vary.

Item / Service	Frequency	Estimated Duration	Estimated Cost
Individual outpatient psychotherapy session (CPT 90834 / 90837)	1x per week	Approximately 1 year or longer	$150–$250 per session

Estimated Total Cost Over 1 Year

Based on weekly sessions at $150–$250 per session, the estimated cost for approximately one year of treatment (roughly 52 sessions) is $7,800–$13,000. Actual cost will depend on your clinician's specific fee, session frequency, and the length of treatment, which is reviewed and adjusted collaboratively with your therapist over time.

Diagnosis and Treatment Plan

This estimate does not reflect a specific diagnosis. The specific services, frequency, and expected duration of your treatment will be discussed with you and may be adjusted based on your individualized treatment plan.

This Estimate Is Not a Bill

This Good Faith Estimate is not a contract and does not obligate you to obtain these items or services from this practice. It shows the estimated costs of items and services that are reasonably expected for your treatment. The estimate is based on information known at the time it was created and does not include unknown or unexpected costs that may arise during treatment.

Your Right to Dispute

If you are billed $400 or more above this Good Faith Estimate for any provider or service listed, you have the right to dispute the bill. You may contact the healthcare provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may contact the U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-985-3059 or visit www.cms.gov/nosurprises for information about the patient-provider dispute resolution process. Initiating a dispute will not affect the quality of care you receive from this practice.

Keep a copy of this Good Faith Estimate for your records. If you have questions about this estimate, please contact our office.

Client Name: _____

Date of Birth: _____

Clinician Name: _____

Estimate Provided On (Date): _____

Estimate Valid Through: _____

Client Signature (optional): _____ **Date:** _____