Judith C Cantor MSW
2012 NE 65th
Seattle WA 98115
206-526-8137
judith@judithcantor.net
judithcantor.net

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference:	☐ By mail	☐ By email
Patient Diagnosis		
Primary Service or Item Requested/Scheduled (Please see attached for a list of itemized services and fees)		

Patient Primary Diagnosis	Primary Diagnosis Code
Patient Secondary Diagnosis	Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Service or Item will be provided:

☐ Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____/_____/_____

Summary of Expected Charges (See the itemized estimate attached for more detail.)

Provider Name	Estimated Total Cost
Judith C Cantor MSW	

Total Estimated Cost: $

The following is a detailed list of expected charges for initial evaluation and on-going psychotherapy services for. "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."

Estimate : Judith C Cantor MSW

Provider/Facility Name Judith C Cantor MSW	Provider/Facility Type Private Practice
Street Address 2012 NE 65th	
City Seattle	ZIP Code 98115
Contact Person Judith C Cantor	Email judith@judithcantor.net
National Provider Identifier 1194898049	Taxpayer Identification Number 91-1811295

Details of Services and Items for Judith C Cantor MSW

Service	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Initial Evaluation Psychotherapy 38-52 minutes Psychotherapy 53-60 minutes	2012 NE 65th Seattle,WA 98115		90791 90834 90837	Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es) or presenting clinical concerns.	This Good Faith Estimate explains your therapist's rate for each service provided. Please note the expected cost is based on the fee times the number of sessions needed as determined in collaboration with your therapist.

Total Expected Charges from Judith C Cantor MSW **$ TBD as stated above**
Additional Health Care Provider/Facility Notes

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care 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 also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health careprovider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 206-526-8137

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or (800) 368-1019.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name: _____

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation	$140.00
	90834	Psychotherapy, 38-52 minutes	$140.00
	90837	Psychotherapy ≥ 53 minute	$140.00
	90839	Psychotherapy for a Crisis (30-74 minutes)	$140.00
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	$70.00
	90846	Family Psychotherapy without Patient Present, 50 minutes	$140.00
	90847	Family Psychotherapy with Patient Present, 50 minutes	$140.00
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at 140.00 per hour
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

GOOD FAITH ESTIMATE SIGNATURE PAGE

Your signature below indicates that your provider (or provider's representative) has gone over this Good Faith Estimate with you any questions or concerns have been addressed. Thank you!

_____

Patient's signature

_____

Print name of patient

_____

Date and time of signature

_____

Guardian/authorized representative's signature

_____

Date of signature

_____

Print name of guardian/authorized representative