GOOD FAITH ESTIMATE

N. Rebecca Fineman, Ph.D.
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Tax ID # 45-4283419
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Patient Name:
Patient DOB:
Parent's Name or Insured:

Patient Address:
Patient Phone:
Patient (parents') email:
Preferred method of contact: Phone (_) or Email (_)

Primary Diagnosis Code: TBD (_) or Currently accepted as _____
Primary Diagnosis Name:_____

Primary Services Requested

Psychological/Neuropsycholgical/Psychoeducational Assessment (_)
Psychotherapy (_)
Consultation WITHOUT assessment associated (_)
IEP/School meeting attendance (_)
Extra Travel Fee (if onsite visit is greater than one hour round trip from office) (_)

Expected Dates of Service for Assessments (services include IN THIS ORDER – parent intake done remotely, school visit, testing sessions, final parent feedback, final patient feedback when appropriate)

_____, _____, _____,
_____, _____, _____,
_____, _____

Hourly fee for Assessments = $450 (this fee include ALL time associated with report writing, e.g., there is no extra charge for report writing; and one hour round

trip travel time from Dr Fineman's office. For trips to schools, patient's home, etc. that are *more than one hour round trip from her office a fee of $250/hour will be charged for any extra travel time)*

Hourly fee for Psychotherapy, Consultation without assessement and IEP Attendance = $350

Estimated number of hour for Assessment_____

Estimated number of hours for Psychotherapy on yearly basis _____**(total number of sessions is unknown at outset of therapy and will be based on the patient's needs, preferences and progress made in therapy)**

Total estimated fee (number of estimated hours multiplied by session fee)=_____

Patient/Patient's Legal Caregiver's Acceptance of Good Faith Estimate

_____

_____ **(date)**

Patient/Patient's Legal Caregiver's Acceptance that Dr. Fineman DOES NOT accept any kind of health care insurance and fees are due at THE TIME OF THE VISIT (unless otherwise agreed between Dr. Fineman and Patient/Patient's Legal Caregiver)

In signing, I/we accept that Dr. Fineman does not accept health care insurance and I/we are responsible to pay Dr. Fineman's above accepted fees to her directly at the time of the visit

_____

_____**(date)**

This estimate is good for one year from date of acceptance