Cynthia A. Dodge, Ph.D.

Possibilities Counseling Center

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 _____

Therapist Signature_____ SW (Printed)_____DATE _____

Patient Signature_____ Patient (Printed)_____ DATE _____