Laurel O'Connor, MA, LMFT 805.699.5028

GOOD FAITH ESTIMATE FORM

Provider Name: Laurel O'Connor, LMFT License: #105148 Provider Tax ID#: 84-4153743
Address: 1625 State Street., Santa Barbara, CA 93101 Phone #: 805-699-5028

Patient(s) or Legal Guardian's Name:_____
Diagnosis (if known/applicable)_____
Services Requested (Check all that apply):

_____Individual therapy ____Couples therapy _____Family therapy _____Group therapy

You are entitled to receive this "Good Faith Estimate" of the charges 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 or family, this form provides an estimate of the cost of services provided. 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.

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.

The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $_____. 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 the fee above, if you attend one psychotherapy visit per week, your estimated charge would be $_____for four visits provided over the course of one month; $_____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.

You have a 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). 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.

Signature(s)_____

Dated: _____