GOOD FAITH ESTIMATE FOR HEALTH CARE SERVICES

Provider Name: Julie Machado, LMFT	License/#: MFT 27937
Provider Address: 22248 Main St, Hayward CA 94541	Provider Phone #: (510) 581-7850
Provider Tax ID#: 45-494-0223	Provider NPI #:1962613364

Patient Name:	Patient DOB:
Patient Address:	
Patient Phone #: ( )	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested: 50-60 minute psychotherapy sessions	

Self-pay consumers are entitled to receive this "Good Faith Estimate" of what the charges could be 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, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. 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. Note that you may be able to receive less expensive care from a different, in-network provider through your insurance.

The fee for a 50-minute psychotherapy visit (in person or via telehealth) is $150, but we have agreed on a sliding scale reduced fee of $65. Most clients will attend one psychotherapy visit per week, but 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 on a sliding scale fee of $65. per visit, the following are expected charges of psychotherapy services:

Number of Weeks	Total estimated charges for 1 session every other week	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per week
1 Week of Service	165.	165.	330.
13 Weeks of Service (3 months)	$1072.50	$2145.	$4290.
26 Weeks of Service (6 months)	$2145.	$4290.	$8580.
39 Weeks of Service (9 months)	$3217.50	$6435.	$12870.
52 Weeks of Service (12 months)	$4290.	$8580.	$17160.

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.

Client's signature _____ Date _____