Good Faith Estimate

Expected charges for therapy, for clients who are uninsured or not using insurance

No Surprises Act · 45 CFR 149.610 · give in writing, on paper or electronically as the client prefers

Practice and estimate

Practice name | Date of estimate | Valid for (12 months max)

Client

Client full name | Date of birth | Account no. (optional)

Has health coverage? ☐ No ☐ Yes Wants a claim sent to it? ☐ No (self pay) ☐ Yes Send by: ☐ Portal ☐ Email ☐ Paper

Primary service and recurring scope

Service in plain words

First session date | Frequency | Timeframe | Total sessions | Diagnosis (if determined)

Itemized estimate (one line per type of service)

Service, in plain words	Service code	Dx code	Qty	Fee each	Expected charge

Total expected charges from this provider $

Provider (repeat for each provider who will bill)

Name and credentials | NPI | Tax ID (EIN)

Office address | Telehealth: client located in state

Services expected to be scheduled separately

Separate Good Faith Estimates will be issued for the services below when they are scheduled or on request. Diagnosis codes, service codes, expected charges and provider identifiers are not listed here; they will be in those estimates. To get one, contact the provider named.

Please read

- This is only an estimate of items and services reasonably expected now. Actual items, services or charges may differ.
- We may recommend additional items or services that must be scheduled or requested separately and are not reflected here.
- This Good Faith Estimate is not a contract and does not require you to get services from any provider listed.
- If you are billed at least $400 more than this provider's total on this estimate, you may dispute the bill. Start within 120 calendar days of receiving the bill; there is a $25 fee. Learn more at www.cms.gov/nosurprises/consumers or 1-800-985-3059. A dispute will not affect the quality of your care. Keep a copy of this estimate.

Replaces estimate dated (if any) | Reason for new estimate (fee, frequency, sessions, provider)

Issued by | Date sent | How sent

Template to adapt. Not legal advice. Compare with the current CMS GFE form and wording, and check state rules.
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Good Faith Estimate

Expected charges for therapy, for clients who are uninsured or not using insurance

FILLED EXAMPLE · fictional practice, clinician and client, for illustration only

Practice and estimate

Practice name	Date of estimate	Valid for (12 months max)
Birch Hollow Counseling	11/16/2026	12 months, to 11/16/2027

Client

Client full name	Date of birth	Account no. (optional)
Taylor K. (fictional)	04/12/1991	

Has health coverage? ☐ No ☑ Yes Wants a claim sent to it? ☑ No (self pay) ☐ Yes Send by: ☑ Portal ☐ Email ☐ Paper

Primary service and recurring scope

Service in plain words: Individual psychotherapy for anxiety: assessment, then weekly 60 minute sessions, then plan review

First session date	Frequency	Timeframe	Total sessions	Diagnosis (if determined)
12/07/2026	Weekly	Dec 2026 to May 2027	1 + 24	Not yet determined

Itemized estimate (one line per type of service)

Service, in plain words	Service code	Dx code	Qty	Fee each	Expected charge
Initial diagnostic assessment	CPT 90791	TBD	1	$180	$180
Psychotherapy, 60 min, weekly	CPT 90837	TBD	24	$150	$3,600

Total expected charges from this provider $ 3,780

Provider (repeat for each provider who will bill)

Name and credentials	NPI	Tax ID (EIN)
J. Ortiz, LMFT (fictional)	0000000000 (ex.)	00-0000000 (ex.)

Office address	Telehealth: client located in state
210 Example St, Suite 3, Springfield, [State]	[State], secure video

Services expected to be scheduled separately

Separate Good Faith Estimates will be issued for the services below when they are scheduled or on request. Diagnosis codes, service codes, expected charges and provider identifiers are not listed here; they will be in those estimates. To get one, contact the provider named.

Possible: medication evaluation with a psychiatric prescriber of the client's choice

Please read

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- This Good Faith Estimate is not a contract and does not require you to get services from any provider listed.
- If you are billed at least $400 more than this provider's total on this estimate, you may dispute the bill. Start within 120 calendar days of receiving the bill; there is a $25 fee. Learn more at www.cms.gov/nosurprises/consumers or 1-800-985-3059. A dispute will not affect the quality of your care. Keep a copy of this estimate.

Replaces estimate dated (if any)	Reason for new estimate (fee, frequency, sessions, provider)
	First estimate

Issued by	Date sent	How sent
J. Ortiz, LMFT	11/16/2026	Client portal

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Before You Send: GFE Checklist

Ten checks for every Good Faith Estimate, plus a log for due dates and renewals

Before you send

- [ ] 1. Asked: coverage, and whether a claim will be submitted.
- [ ] 2. Due date set: 1 or 3 business days after booking or request.
- [ ] 3. Client name, date of birth, service in plain words.
- [ ] 4. Recurring scope: timeframe, frequency, total sessions.
- [ ] 5. Each service: code, Dx code if needed, qty, fee, total.
- [ ] 6. Fees reflect the sliding scale or discount actually used.
- [ ] 7. NPI, Tax ID, office address and telehealth state listed.
- [ ] 8. Separately scheduled services listed under their disclaimer.
- [ ] 9. All disclaimers and dispute information, current CMS wording.
- [ ] 10. Sent in writing as client prefers; copy filed in the record.

GFE log: re-issue when the fee, frequency, sessions or provider change

	Client code	Booked / asked	GFE due	Sent (date, how)	Total $	Renew by
1.						
2.						
3.						
4.						
5.						
6.						

Timing reminders:

Booked 3 to 9 business days ahead: send within 1 business day. Booked 10 or more ahead or asked for an estimate: within 3. Changes: at least 1 business day before. Recurring: 12 months max.

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