Whole Senior Care LLC

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NPI #1205133402 TIN #27-4772627

Good Faith Estimate

Patient Name:_____ Date of Birth:_____

Type of Services Provided:_____

Diagnosis and Treatment Codes: To be determined

Estimated Length of Services Provided: To be determined

Locations of Patient and Therapist :_____

Description of Treatment Modality(ies) Used:_____

Treatment Goals:_____

Estimated Charges for each Service Provided: $125 per session

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 by (check one):

___ in person ___ online ___ US mail ___ other: _____

____Patient declined need for copy of document; document can be found in patient's chart

LCSW Signature_____ LCSW (Printed)_____DATE _____

Patient signature confirms that LCSW inquired about insurance, whether patient will submit to insurance and received understanding of this from patient:

Patient Signature_____ Patient (Printed)_____ DATE _____