Nicole Ashton, LMFT

EMDR & PSYCHOTHERAPY

GOOD FAITH ESTIMATE

Provider Name: Nicole Ashton License #: 45884
Provider Address: 3685 Motor Avenue, Suite 220 Los Angeles, CA 90034
Phone #: (310) 592-8274
Provider Tax ID:36-4645205 Provider NPI # 1093922585

Patient Name:
Patient DOB:
Patient Diagnosis (if known/applicable):
Services: Weekly Psychotherapy- 50 mins (CPT Code 90834)

You 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.

As a client-centered practice, I empower clients to determine their own course of mental health treatment, including frequency and length of treatment. Fees are paid per session at a rate of $____. Therefore, if you were to

attend therapy one time per week for 52 weeks per year, your annual service estimate would equal $____.

A helpful calculator is included below to determine your annual estimated cost of service, depending on the frequency of sessions you choose to book:

(___ # of Sessions) x ($___ Session Fee) = (Total Estimated Annual Cost)

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

Date of this Estimate: _____

Signature: _____

Print Name:_____