GOOD FAITH ESTIMATE

[Note: This form is intended to provide a current or prospective patient with a "Good Faith Estimate" (GFE) of expected charges for services provided pursuant to the No Surprises Act.]

Provider Name	Philip Manfield, PhD License/: CA LMFT #MFT7169
Provider Address:	1205 Brighton Ave., Albany, CA 94706
Provider Phone #:	510-457-6239
Provider Tax ID#94-301-1046	Provider NPI #: 1396896726
Diagnosis (if known/applicable):	
Patient Name:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (If known/applicable)	
Service Requested: Psychotherapy	

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 Dr. Manfield, 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 Dr. Manfield. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

This Good Faith Estimate is for recurring services for as long as you and Dr. Manfield are comfortable with, depending on the nature of the services, not to exceed 12 months. If services should extend beyond 12 months, Dr. Manfield will draw up a new Good Faith Estimate for you. The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $240. 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 and inclinations.

Based upon a fee of $240 per visit, if you attend one psychotherapy visit per week, your estimated charge would be $960 for four visits provided over the course of one month; $1920 for eight visits over two months; $2880 for twelve visits over three months; or $10,820 for 48 visits over twelve 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 this 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.

DR. MANFIELD IS NOT A PREFERRED PROVIDER FOR ANY HEALTH INSURANCE COMPANIES: He is not on any of their preferred panels and is not one of their in-network providers. Although many insurance companies will pay for some of Dr. Manfield's services, with limits determined by the company and the client's policy, almost none will pay his full fee of $240 per 50 minute session. It is the client's responsibility to determine how much his or her insurance carrier will pay and for which services. Clients are responsible to pay Dr. Manfield's fee at the time service is provided, and it is then up to them to seek whatever reimbursement they are able to obtain from their insurance carriers. Upon request, Dr. Manfield will supply clients from time to time with an itemized receipt that they may want to present to their insurance carrier. Dr. Manfield does not maintain a professional or business relationship with any insurance companies. Federal and State laws requires you to acknowledge that you understand the information in the above document.

Client initial here:_____ Date: _____

Date of this Estimate _____