OLSON MFT CLINIC
GOOD FAITH ESTIMATE

At The Gerald & Audrey Olson Marriage & Family Therapy Clinic (Olson Clinic) therapy is conducted by students under the supervision of Licensed Marriage and Family Therapists and AAMFT-approved supervisors/supervisor candidates.

Student Clinician Name:_____

Supervisor Name	***License Number***	***NPI Number***
Dr. Tabitha Webster	093094	1053618686
Dr. Heather Morgan-Sowada	000388	1427449503
Dr. Anthony Mielke	093697	1578082848
Dr. Douglas McPhee	110008	1023638673

Olson Clinic Phone: 319-368-6493
Olson Clinic Address: 1650 Matterhorn Dr. NE, Cedar Rapids, IA 52402
Tax ID: 420681046

Patient Name:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested:	

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.

The fee for a 45-minute psychotherapy visit (in-person or via telehealth) is $_____. 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 upon a fee of $_____ per visit, if you attend one psychotherapy visit per week, your estimated charge would be $_____for four visits provided over the course of one month; $_____for eight visits over two months; or $_____for 12 visits over three 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 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 _____