Doric George MA
1223 Wilshire Blvd., Unit 771
Santa Monica, CA 90403
310.717.1771

Self-Pay Agreement

Client Name: _____ Date of Birth:_____

Address: _____

Phone: _____ Email: _____

Service Required: _____

I, _____ (The Client), have instructed the therapist, Doric George MA not to bill any third party payers (i.e. insurance companies, reimbursement plans, medical credit or health savings accounts, or any others) for one or more of the following reasons:

(1) I have no medical coverage at this time.

(2) I have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement.

(3) I have insurance coverage, but understand that the services of Doric George MA are not covered by the plan.

(4) Other:

I also state that I have no secondary insurance or reimbursement plan and will not seek reimbursement from any third party medical reimbursement organization or health savings account.

If this situation changes and I, the client, would like to seek coverage or reimbursement from a third party payer, negotiated fees may need to be reset retroactively in light of new financial resources and third party requirements.

I also understand the following:

Currently arranged session cost is based on attending weekly appointments and is subject to periodic review. If 2 sessions are missed for any reason within a 6 month period, session costs could change without notice and standing appointment times could be forfeit;

Fee adjustments maybe made with written and verbal notification at least 2 weeks prior going into effect;

If 2 consecutive weekly sessions are missed, fees are subject to re evaluation and may be reset to a more current rate.

Furthermore, 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 that may be recommended during treatment 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 50-minute psychotherapy visit (in person or via telehealth) is $_____. Most clients will attend one psychotherapy visit per week, but the frequency and duration of psychotherapy visits that are appropriate in your case may be different, depending upon your needs. Based on this per visit fee cited above, the following are expected charges of psychotherapy services:

Number of Weeks	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per week
1 Week of Service	$	$
13 Weeks of Service (Approx. 3 Months)	$	$
26 Weeks of Service (Approx. 6 months)	$	$
39 Weeks of Service (Approx. 9 months)	$	$
52 Weeks of Service (Approx. 12 Months)	$	$

You have a right to dispute a bill 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). Initiating the dispute process will not adversely affect the quality of services rendered to you. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

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.

Client's Name (Printed) Signature Date