

# Lynn Fainsilber Katz, Ph.D.

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## **GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES**

*(If you are seeking treatment as a couple, please have each partner fill out the information in the blue spaces directly below):*

<b>Partner 1 Name</b> _____	<b>Gender</b> _____	<b>Date</b> _____
<b>Birth Date:</b> _____		
<b>Address</b> _____		
_____ <b>Street</b>	_____ <b>City</b>	_____ <b>State</b> <b>Zip Code</b>
<b>Cell Phone</b> (____) _____	<b>Home Phone</b> (____) _____	
<b>Email</b> _____		
<b>Contact Preference:</b> <input type="checkbox"/> By email <input type="checkbox"/> By mail		

<b>Partner 2 Name</b> _____	<b>Gender</b> _____	<b>Date</b> _____
<b>Birth Date:</b> _____		
<b>Address</b> _____		
_____ <b>Street</b>	_____ <b>City</b>	_____ <b>State</b> <b>Zip Code</b>
<b>Cell Phone</b> (____) _____	<b>Home Phone</b> (____) _____	
<b>Work Phone</b> (____) _____	<b>Email</b> _____	
<b>Contact Preference:</b> <input type="checkbox"/> By email <input type="checkbox"/> By mail		

(The information in the space directly below will be completed by Dr. Katz):

**Client diagnosis:** \_\_\_\_\_

**Service: Psychiatric Evaluation; Family Psychotherapy; and/or Individual Psychotherapy**

**Expected Service Code: 90791; 90847; and/or 90837**

**Provider Name: Lynn Fainsilber Katz, PhD; Tax ID 47-5547872; UBI 603-545-947**

**Services Provided: 4915 25<sup>th</sup> Avenue NE, Suite 202 West, Seattle, WA 98105  
or via telehealth**

**Date of Good Faith Estimate:** \_\_\_\_\_

### **FINANCIAL INFORMATION**

**FEES:** The charge for individual therapy is \$250.00 for a 50-minute session. Fees for couples therapy are: \$250 for a 50-minute session (assessment and therapy services); \$325 for a 75-minute session (therapy); \$450 for a 90-minute session (therapy); and \$500 for a 100-minute session (assessment and therapy services). Fees for Gottman Marathon Couples Therapy is \$6000.

The ultimate treatment fee for ongoing psychotherapy will be the number of sessions multiplied by the ongoing session fee. The number of total sessions in the treatment is unknown at the outset and is based on your needs, preferences, and the progress made in treatment.

There may be additional items or services that Dr. Katz may recommend as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate (e.g., an individual meeting with Dr. Katz during the course of couples therapy, which is charged at the same rate as for individual therapy listed above).

The information provided in this Good Faith Estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued. Actual items, services or charges may differ from the good faith estimate.

### **PATIENT RIGHTS**

You have the right to initiate a specific dispute resolution process if the actual bill charges are substantially in excess of the expected charges included in the Good Faith Estimate. The initiation of a dispute resolution process will not adversely affect the quality of health care services provided by Dr. Katz.

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 and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to <https://www.cms.gov/nosurprises/consumers> or call 1-800-985-3059. **For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit <https://www.cms.gov/nosurprises/consumers> or call 1- 800-985-3059.

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.

This Good Faith Estimate is not a contract and you are not required to obtain services from Dr. Katz.

By signing below, you indicate that you have read and reviewed this document, "Good Faith Estimate for Health Care Items and Services" and agree to the terms within.

\_\_\_\_\_  
**Partner 1 Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Partner 2 Signature**

\_\_\_\_\_  
**Date**