Jewish Family Service
of MetroWest New Jersey

GOOD FAITH ESTIMATE

STATEMENT AND DISCLAIMER: If you are uninsured or insured but self-pay, you have the right to receive a Good Faith Estimate (GFE) for services. This estimate may change as the treatment progresses and is not a guarantee of treatment frequency, length or cost. If services are added or changed, you will receive a new GFE. Your signature does not create a contract or require you to receive psychotherapy services from JFS. If actual costs of services greatly exceed the estimate, you may initiate dispute resolution (DR) by contacting the Department of Health and Human Services within 120 days. Initiating DR will not adversely affect your quality of care.

Client Name_____
Date of Birth _____

Type of Services
Provided_____

Diagnosis Code
_____

Treatment Code
_____

Estimated Length of Services Provided
_____

Estimated Charges for each Service Provided
_____

I have received a copy of this document and my clinician has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

Client Signature_____
DATE _____

Guardian Name Printed _____ DATE _____
(If client is a minor)

Guardian Signature _____

JFS Clinician Signature_____ DATE _____