RAVIT AVNI-SINGER, MSW LCSW

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GOOD FAITH ESTIMATE

Date: ___________________________________

Client Name: ____

Date of Birth: _____________________________

Estimate Type of Service Provided: ____

Estimate Length of Service Provided: ____

Location of Client and Clinician: ____

Modality(ies) of Treatment Provided: ____

Treatment Goals: ____

____

Estimated Charge for Each Service Provided: ____

Disclaimer: These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length of cost. Your signature does not require you to receive psychotherapy services from me.

LCSW signature: ____

(printed) ____

Client signature: ____

(printed) ____