Steven Korner, Ph.D.

Licensed Psychologist #1584NJ. #7016NY

135 County Road

Cresskill, NJ 07626

Good Faith Estimate for Health Care Items and Services

Patient

Patient First Name Middle Name Last Name _____

Patient Date of Birth: _____/_____/_____

Patient Mailing Address, Phone Number, and Email Address

Street or PO Box Apartment _____

City State ZIP Code _____

Phone _____-

Email Address _____

Patient's Contact Preference: [ ] By mail [ ] By email

Patient Diagnosis

Primary Service or Item Requested/Scheduled _____

Patient Primary Diagnosis Primary Diagnosis Code _____

Patient Secondary Diagnosis Secondary Diagnosis Code _____

If scheduled, list the date(s) the Primary Service or Item will be provided:

_____

[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____/_____/_____

Summary of Expected Charges

(See the itemized estimate attached for more detail.)

Provider Name Steven Korner, Ph.D. Estimated Total Cost _____

[Provider/Facility 1] Estimate

Provider/Facility Name	Steven Korner, Ph.D.	
Provider Type Street	Licensed Psychologist	
Address	135 County Road	
City State ZIP Code	Cresskill, NJ 07626	
Contact Person	Steven Korner, Ph.D.	
Phone	201 894-8881	
Email	drkorner@aol.com	
National Provider Identifier	NPI# 1124037981	Taxpayer Identification EIN # 04-3795347

Number Details of Services and Items for [Provider/Facility 1]

Address

Service	Diagnosis Code	Service Code	Quantity	Expected Cost*	Total Expected Charges*
Individual/Family Therapy		90791, 90834, 90847, 90846	1	$225	$225

*Monthly cost for one visit/week would be $900. Length of time for treatment TBD.

Additional Health Care Provider/Facility Notes

Services involving record reviews, evaluation reports are charged on the hourly basis of $250/hour
Neuropsychological evaluations (full) fee is $4800
Testing with individual tests are charged at $250/hour for administration, scoring, and review of findings.

This Good Faith Estimate explains the rate for each service provided. I will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

There may be additional items or services recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.

The information provided in the 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 and that actual items, services, or charges may differ from the good faith estimate.