

**Klockner Counseling, LLC**  
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**2732 NE Broadway St., Portland, OR 97232 503-327-4839**

**Good Faith Estimate for Health Care Items and Services**

<b>Patient</b>			
Patient Full Name:		Date of Birth: ____ / ____ / ____	
Street or PO Box			
City		State	Zip Code
Phone			
Primary Diagnosis (if applicable) ____ Deferred _____			
Diagnosis code: _____			
Secondary Diagnosis (if applicable) _____			
Diagnosis code: _____			
Date(s) of Service	Description	Service Code	Estimated amount to be billed
Total estimate of what you may owe			
Provider signature:		Date:	
NPI (if applicable) 11142188880			

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

**Disclaimer**

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above

\_\_\_\_\_  
 Patient Name  
 Date \_\_\_\_\_

\_\_\_\_\_  
 Patient or Guardian’s Signature