

Daniel B. Goldman, Ph.D., LLC

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Psychologist providing services: Daniel B. Goldman, Ph.D., FL Lic. PY8470, APIT # 15454

NPI number: 1073877643 / 1154699189

EIN/TIN: 45-5558318

This estimate is for professional psychological services, typically including but not limited to psychotherapy and psychological testing services, through 12/31/2026. The estimate below is the range of costs that is likely for patients **who are not using insurance** to pay for their care. Patients who use insurance benefits to pay for their care will have varying copays and coinsurances, and their total cost of care may be significantly lower than the estimates provided in this document. I see therapy patients for anywhere between a single session to a number of years depending on their unique needs and goals, however the patient always remains empowered to choose the length of their treatment and has the right to terminate treatment at any time without any financial penalty. As a result of the wide range of times and subsequent number of sessions preferred or needed by various patients, the total cost of treatment ranges vastly and cannot be estimated accurately.

Contact: If you have questions about this estimate, please contact Dr. Goldman directly at (941) 444-5578 or dan@sarasotapsych.com.

Details of the Estimate

Below is an itemized table of psychological services with associated costs that allows you to calculate the anticipated total cost of care in 2026.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. 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 this happens, federal law allows you to dispute (appeal) the bill.

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy. You may thus calculate a total estimate based on your goals for therapy using the fees/rates listed below. 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, and treatment goals.

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

You may contact Daniel Goldman, Ph.D., to let him know the billed charges are higher than the Good Faith Estimate. You can ask to negotiate the bill or ask if there is financial assistance available.

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:

www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.

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 more than \$400 than the estimate provided above.

Sample Good Faith Estimate

Below is a sample of costs you might incur based on the frequency and duration of care you choose to pursue. Fees are identical for care that is provided in-person and that which is provided via telehealth. On the following page, you will find a more complete table of services and fees to use in calculating the cost of care should your care needs go beyond the basic table below.

Cost per therapy session	\$210 per 53-60 min.	\$175 per 38-52 min.	\$115 per 16-30 min.
1 month of therapy (weekly)	\$840	\$700	\$460
1 month of therapy (every other week)	\$420	\$350	\$230
3 months (12 weeks) of therapy (weekly)	\$2520	\$2100	\$1380
3 months of therapy (every other week)	\$1260	\$1050	\$690
6 months (24 weeks) of therapy (weekly)	\$5040	\$4200	\$2760
6 months of therapy (every other week)	\$2520	\$2100	\$1380
12 months (48 weeks) of therapy (weekly)	\$10800	\$8400	\$5520
12 months of therapy (every other week)	\$5040	\$4200	\$2760

GOOD FAITH ESTIMATE TABLE OF SERVICES AND FEES

Service code (CPT Code)	Description	Fee for Service (Number of Each Service Will Be Decided by the Patient Based on Their Treatment Goals Unless Otherwise Specified in This Document)
90791	Initial Diagnostic Evaluation	\$225.00
90832	Psychotherapy, 16-37 minutes	\$115.00
90834	Psychotherapy, 38-52 minutes	\$175.00
90837	Psychotherapy ≥ 53 minutes	\$210.00 (General references heretofore to “hourly rate” refer to this figure, which is used to prorate fees when indicated, except legal fees)
90839	Psychotherapy for a Crisis (30-74 minutes)	\$210.00
90840	Psychotherapy for a Crisis (add-on code for each additional 30 minutes)	\$115.00
96130-96131	Psychological Testing Evaluation Services	\$200.00
96136-96137	Psychological Testing (Administration & Scoring)	\$100.00
98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at hourly rate
98970-98972	Online Digital Evaluation & Management (Responding to Email/Text Messages)	Prorated based on the amount of time spent at hourly rate
Late Cancellation or Missed Appointment Fee	Your Provider Requires a 48-Hour Cancellation Notice; No Fee is Assessed When at Least 48 Hours’ Notice is Provided	You are responsible for the full fee for service for missed appointments or cancellations made with less than 48 hours’ notice
Production of Records	Copying, scanning, faxing, and emailing	\$1.00/page for first 20 pages; \$0.25/page thereafter
Legal/Forensic Fees	All time spent preparing for, commuting to/from, or attending legal proceedings.	\$400.00/hour; full payment required 10 days in advance; no refunds will be provided for unused time
Total Estimate:	This Good Faith Estimate explains your provider’s rate for each service provided. It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy. You may thus calculate a total cost estimate based on your goals for therapy using the fees/rates listed above. Your therapist 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, and treatment goals.	

* Place of Service (in office vs. telehealth) is not delineated above since the charges are identical.