COURAGE COUNSELING
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Good Faith Estimate for Health Care Items and Services

Patient			
Patient Full Name:		Date of Birth:____/___/_____	
Street or PO Box			
City	State **TX**	Zip Code	
Phone			
Primary Diagnosis (if applicable) __Pending Clinical Interview_____ Diagnosis code: ____n/a_____			
Secondary Diagnosis (if applicable) __Pending Clinical Interview _____Diagnosis code: __n/a_____			
Date(s) of Service	Description	Service Code	Estimated amount to be billed
Weekly	Psychotherapy Individual 45 min	90834	160.00 * 48 = $7,680.00
Weekly	Psychotherapy Group	90853	45.00 * 48 = $2,160.00
Total estimate of what you *may* owe for 12 months of care. Using less than above services would reduce the annual total cost of care proportionally.			**$9,840.000**
Provider signature: *Priscilla Elliott, MA, LPC*		Prepared Date: 2/16/2022	
EIN/Tax ID # 47-5364909		NPI 1255619201	

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 Patient or Guardian's Signature Date