



Patient			
Patient Full Name:		Date of Birth: ____/____/____	
Street or PO Box			
City		State TX	Zip Code
Phone			
Primary Diagnosis (if applicable) <u>Pending Clinical Interview</u>		Diagnosis code: ____ n/a ____	
Secondary Diagnosis (if applicable) <u>Pending Clinical Interview</u>		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	50.00 * 48 = \$2,400.00
Total estimate of what you <u>may</u> owe for 12 months of care. Using less than above services would reduce the annual total cost of care proportionally.			\$10,080.00
Provider signature: <i>Priscilla Elliott, M.A., LPC</i>		Prepared Date: 2/16/2022	
EIN/Tax ID # 47-5364909		NPI 1255619201	

Disclaimer

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

Patient Name	Patient or Guardian's Signature	Date
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