

3625 Menchaca Rd. Ste. 303 Austin, TX 78704 Ph: 512-673-3987 Priscilla@courage-counseling.com Courage-Counseling.com

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	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: Pr	iscilla Elliott, MA, LPC	Prepared Date: 2,	Prepared Date: 2/16/2022	
EIN/Tax ID # 47-5364909		NPI 1255619201	PI 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. After first session, client may ask for Primary Diagnosis and Diagnosis code. Also, may need to specifically request superbill for insurance purposes.				
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 Gu	uardian's Signature	Date	