Center For Positive Change LLC

Good Faith Estivate for Health Care Items and Services

For Patients Who Don't Have Insurance or Who Are Not Using Insurance

_____ _____ _____

Patient First Name Middle Last

Patient DOB _____

_____ _____ _____ _____

Street/PO Box City State Zip

_____ _____

Phone Email

_____ _____

Primary Service (i.e., psychotherapy) Secondary Service (i.e., testing)

_____ _____

Primary Diagnosis Service CPT Code

_____ _____

Additional Diagnosis Service CPT Code

*Estimated number of sessions ____ *Estimated number of hours ____

*Estimated cost per session _____ *Estimated cost per hour _____

Total Estimated Costs $ _____ $_____

Provider Name _____ Signature _____

Patient Name _____ Signature _____

*The above is a good faith **estimate** of services and charges. The outcome may vary due to circumstances