Good Faith Estimate for Wellspring Counseling Center Services
(Applies to Self-Pay Patients)

Patient Full Name: _____ Date of Birth: _____
Street Address_____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ (number for guardian if patient is a minor)

(To Be Completed by Provider):
Diagnosis and Diagnosis Code_____

Billed Services

Date of Service	Description	Service Code	Billed Amount
	/ Initial Office Visit	**/ 90791**	**/ $150.00**
As Needed /Psychotherapy / Either:		**90837, 90834, or 90847**	**/Charges as Listed Below**

90837: $153 (53 – 60 minutes) Individual Treatment
90834: $115 (38 – 52 minutes) Individual Treatment
90847: $115 (38 minutes or longer) Marital/Couples or Family Therapy

The patient will be notified at least three months in advance of any increase in fee for services at Wellspring Counseling Center.

Provider Signature_____ Provider NPI_____
Provider Tax ID: 20-2850124
Patient or Guardian's Signature_____
Date:_____