Centered Practice
Good Faith Estimate
Individual & Family Therapy

This estimate is for clients who are choosing self-pay or who are uninsured

Clinic Rates for Services*

Service	Code	Unit Rate
Diagnostic Assessment	90791	$255
Individual Therapy 53 min	90837	$200
Individual Therapy 38-52 min	90834	$155
Individual Therapy 16-37 min	90832	$110
Family Therapy, no client	90846	$200
Family Therapy	90847	$200

Good Faith Estimate:**

1 Diagnostic Assessment Unit @ $_____

____ Therapy Session Units @ $_____

Total Estimated Cost: $_____

_____

Provider Name:

Signature:

Date:

Client Information

Client Name:
Client Date of Birth:
Services Include: Diagnostic Assessment Individual Therapy and/or Family Therapy
Does the identified client have a qualifying mental health diagnosis? Yes Not Yet Assessed If client does not meet criteria for mental health services, they will only be charged for the initial assessment

*Please know that if you are experiencing hardship and do not have the financial means, you may reach out to your therapist who can discuss their own discounted rates for individuals who are uninsured.

**Client and therapist will discuss and agree on length of care (number of sessions) after the initial assessment and ongoing, based on client symptom reduction and client agreement. A new estimate will be provided as needed.

_____

Client Name:

Signature:

Date: