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302-635-0505
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Center for Grief and Trauma Therapy

FEDERAL TAX ID: 81-3077315
GROUP NPI#: 1932550027

More details about your estimate

Patient name:

Date of Birth: _____

Out-of-network provider(s) or facility name: Center for Grief and Trauma Therapy

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may haveto pay.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Client Name:

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress &)
	90791	Initial Diagnostic Evaluation	175.00
	90832	Psychotherapy, 16-37 minutes	75.00
	90834	Psychotherapy, 38-52 minutes	125.00
	90837	Psychotherapy ≥ 53 minutes (This fee is my hourly rate & used for all prorated calculations as indicated)	150.00

	90839	Psychotherapy for a Crisis (30-74 minutes)	175.00
	+90840	Psychotherapy for a Crisis (add on code for each additional 30 mins)	87.50

	90846	Family Psychotherapy without Patient Present, 50 minutes	175.00
	90847	Family Psychotherapy with Patient Present, 50 minutes	175.00
	90853	Group Psychotherapy	60.00
	98966-98968	Telephone Assessment & Management F	of time spent at hourly rate per 15 minutes
	98970-98972	Online Digital Evaluation & Mgt (Responding to Email & Text Messages)	Prorated based on the amount of time spent at hourly rate
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records		0
		ıate: This Good Faith Estimate explains your therapist's rate for each provided. Your therapist will collaborate with you throughout your letermine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.

-or

Patient's signature Guardian/authorized representative'ssignature Print name of patient ~~Print name~~

~~of guardian/authorized representative~~ Date and time of signature Date and time of signature