**Healing Heart Counseling Center**
820 Jordan Street, Suite 401
318-222-6800, healingheart820@gmail.com

# Good Faith Estimate for Health Care Items and Services

| **Patient** |
| --- |
| First and Last Name: |
| Date of Birth (mm/dd/yyyy): |
| Identification Number: |
| **Patient Contact Information** |
| Address: |
| Phone: |
| Email: |
| Contact Preference: [ ] text [ ] call [ ] email |
| **Patient Diagnosis** |
| Primary Service or Item Requested/Scheduled<br>(Please see attached for a list of itemized services and fees) |
| Primary Diagnosis: |
| Secondary Diagnosis: |

| |
|---|
| If scheduled, list the date(s) Primary Service or Item will be provided:<br><br>[ ] check this box if this service or item is not yet scheduled |
| Date of Good Faith Estimate: |
| **Summary of Expected Charges**<br>(see the itemized estimate attached for more detail) |
| Provider Name: Emily Kirby<br>Estimated Total Cost:<br>$125 per session at 12-48 sessions in 12 months comes to $1500-$6000 |
| **Total Estimated Cost:** |
| The following is a detailed list of expected charges for counseling/psychotherapy or other services, scheduled for [_/_/20__], and recurring one to four times a month. "The estimated costs are valid for 12 months from the date of the Good Faith Estimate." |