



Cashman Center
Therapies for Mind & Body

Good Faith Estimate

Client Full Name: Private Pay Cashman Center Client
Date of Birth:
Client Number:
Client Mailing Address:
Client Phone Number:
Client Email Address:
Client's Contact Preference: Email <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/>
Primary Diagnosis:
Primary Service Requested: Intake/Diagnostic Assessment for Individual Counseling
If scheduled, list the date this service will be provided: Service is not yet scheduled: _____
Date of Good Faith Estimate: / / 2022
Codes Used for Service: 90791: <input checked="" type="checkbox"/> Cost out of pocket: 250.00
Total Estimated Cost for Service: \$250.00

