Good Faith Estimate Form

PATIENT INFORMATION

[ClientInfo]: _____

Contact preference:

- [ ] Email
- [ ] Phone
- [ ] Mail

MAILING ADDRESS

Street: _____ Apartment: _____

City: _____ State: _____

Zip code: _____ Email: _____

Phone: _____

DIAGNOSIS INFORMATION

Primary diagnosis: _____ Secondary diagnosis: _____

Diagnosis codes (If known): _____

SCHEDULING INFORMATION

Select one:

◯ Scheduled ◯ Not scheduled

If scheduled, list the date of the service: dd / mm / yyyy

If not scheduled, list details of the service timeline:

HEALTH CARE ITEMS AND SERVICES INCLUDED IN THE ESTIMATE

The estimate must include a list of health care items or services reasonably expected to be provided:

PRIMARY SERVICE OR PROCEDURE

Description:

Expected charge: _____

ADDITIONAL SERVICES (IF ANY)

1. Description:

Expected charge: _____

2. Description:

Expected charge: _____

If applicable, include services from other providers or facilities involved in the care.

DISCLAIMER

This good faith estimate form outlines expected charges based on current information. It does not account for unforeseen costs that may arise.

Patients have the right to dispute any charges that differ significantly from this estimate.

ACKNOWLEDGMENT

☐ I, , acknowledge receipt of this good faith estimate form.

Signature:

Date: _____ dd / mm / yyyy