

Good Faith Estimate for Health Care Items and Services

Patient			
Patient First Name	Middle Name	Last Name	
Patient Date of Birth:	/	1	
Patient Identification Number:			
Patient Mailing Address, Pho	one Number, and	d Email Address	
Street or PO Box		Apartment	
City	State	ZIP Code	
Phone			
Email Address			
Patient's Contact Preference:	[] By mail	[] By email	
Patient Diagnosis			
Primary Service or Item Requested/Scheduled			
Patient Primary Diagnosis	F	Primary Diagnosis Code	

If scheduled, list the date(s) the Primary Service or Item will be provided: [] Check this box if this service or item is not yet scheduled			
Date of Good Faith Estimate:	/	/	
Ducyddar Neme	Estimated Total Cost		
Provider Name	Estimated Total Cost		
Provider Name	Estimated Total Cost		
Provider Name	Estimated Total Cost		
Total Estimated Cost: \$			

The following is a detailed list of expected charges for Physical Therapy Services, scheduled for ______. <u>Circle One</u>: One Time Visit/Re-occuring. (The estimated costs are valid for 12 months from the date of the Good Faith Estimate.)

Detailed Estimate

Provider/Facility Name: FYZICALTherapy & Balance Center		Provider/Facility Type: PT
Street Address: 430 W. Cherry St.		
City: Jesup	State: GA	ZIP Code: 31545
Contact Person: Amber Myers	Phone: 912-256-5610	Email: jesup@fyzical.com
National Provider Identifier: 1306331756		Taxpayer Identification Number: 82-5377148

Details of Services and Items

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges \$

Additional Health Care Provider/Facility Notes

Provider/Facility Name	Provider/Facility Type		
Street Address			
City	State	ZIP Code	
Contact Person	Phone	Email	
National Provider Identifier	Taxpayer Identification Number		

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to <u>www.cms.gov/nosurprises</u> or call <u>1-800-985-3059</u>.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit <u>www.cms.gov/nosurprises</u> or call <u>1-800-985-3059</u>.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount