Good Faith Estimate for Cash and non-insurance Items

Patient Name:	Date of Birth:

Estimated Services and Items		**From Beginning of Care**	**Covers All Dates of Service**	
Description (clear language)	**Diagnosis Code (ICD-10 Code)**	**Service Code (CPT, HCPCS, DRG)**	**Quantity**	**Expected Cost**
Primary service description here (P)	On Pt. Request	On superbill /visit	Vary/visit	Vary/visit
Initial Exam			1st to1 yr	$99.00
Progress Exam			One/1st month then 6 or > months	$69.00
1-2 Levels CMT/ 3-4 Levels CMT			Per visit	$30.00/$40.00
Extra-spinal CMT			Per visit	$5.00
Therapies/Acupuncture			Per visit	$15-$65.00
Crisis/Corrective Care			2-3x/week	
Maintenance/Supportive Care			2-4 wks intervals	

P - Primary Service (initial reason for visit) C – Co-provider services R - Reoccurring Services or item (valid for up to 12 months from date on this form)	**Total Expected Charges $**	
	Date of Good Faith Estimate:	

Disclaimers: There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate. This document covers all physicians and providers of this facility. treatment. The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate. The patient recognizes and agrees that as their condition can vary, this estimate is subject to change and therefore it is not necessary upon each visit, as well as that their verbal consent to care alone is acceptable. You have the right to initiate the patient-provider dispute resolution process only if the actual billed charges are $400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. However, as this patient signs and receives a superbill receipt requesting these identified services upon each visit, this patient agrees and accepts full financial responsibility, that these fees are due at the time of service making it unlikely to ever exceed $400 more than expected, and that these fees are nonrefundable and nonbillable to insurance. Fees not under consideration are convenience fees, supplements, diagnostics, durable goods, or orthotics. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us 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 within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

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Patient Signature **Witness** **Date**