Brookside Medical Center

Good Faith Estimate Form

Patient information		
First name: Maria	Middle name: L.	Last name: Jensen
Date of birth: Jensen	Contact preference: ☑ Email ☐ Phone ☐ Mail	
Mailing address		
Street: 789 Oakwood Dr.	Apartment: Apt 3D	
City: Chicago	State: IL	Zip code: 60601
Email: maria.jensen@email.com	Phone: (555) 987-6543	
Diagnosis information		
Primary diagnosis: Acute Migraine		
Secondary diagnosis: Anxiety Disorder		
Diagnosis codes (If known): G43.909, F41.9		
Scheduling information		
☑ If scheduled, list the date of the service: 01/20/2024		
☐ 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
Neurological Consultation for Acute Migraine Treatment	$ 400.00
Additional services (if any):	
Description	**Expected charge**
MRI of the Brain for Migraine Evaluation	$ 1,000.00
Medication for Acute Migraine Relief	$ 150.00

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, Maria L. Jensen, acknowledge receipt of this **good faith estimate form**.

Signature: **Maria L. Jensen** **Date:** 01/10/2024