

Good Faith Estimate Form

Patient information			
First name:	Middle name:	Last name:	
Date of birth:	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			
If scheduled, list the date of the service:			
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):			
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:** _____