2026 Good Faith Estimate for Health Care Items and Services

Patient Demographics	
Last Name, First Name, Middle Initial:	
Date of Birth:	
Patient Identification Number:	
Patient Mailing Address:	
Phone Number:	
Email Address:	
Patient's Contact Preference (check box): Mail ☐ Email ☐	

Patient Diagnosis (self-reported)	
Primary Service or Item Requested/Scheduled:	
Primary Diagnosis:	
Primary Diagnosis Code:	
Secondary Diagnosis:	
Secondary Diagnosis Code:	

Scheduling	
Date(s) the Primary Service will be provided:	
Check box if this Service is not yet scheduled:	

Provider Group Information	
Name:	
Address:	
Phone Number:	
Email:	
Tax ID	
NPI:	

Date of Good Faith Estimate:		
Good faith estimate will be updated if changes in patient care plan significantly alters estimated cost. The estimates provided below are per visit and charges will recur with each visit. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Ancillary services may not be required during each visit and are ordered as designated by plan of care.		
Service Type	**Frequently Associated CPT Codes***	**Estimated Amount**
Routine Visit:	99341-99350	$50.00-200.00
Care Plan Oversight	G0179	$42.00
Lab Work (Ancillary):	85025, 84443, 83036	$10-$20
X-ray(Ancillary):		
Setup	Q0092	$26.00
Transport	R0070/75	$185.00
Exam	71045,71046	$25.00-35.00

***The CPT Codes listed are based on regularly provided services per service type. Rates are updated as required based on management review.**

Disclaimer

The information provided in this good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time this good faith estimate is issued to you and actual items, services, or charges may differ from this good faith estimate. There may be additional items or services that your provider recommends as part of your course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

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 www.cms.gov/nosurprises or call 1-800-985-3059.

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 this good faith estimate.