<Organization Name>

Good Faith Estimate Form

Date Created: ______________________

Patient Information:	
Patient Legal Name:	Patient DOB:

Did Patient: (Y/N)

Y N	Schedule an appointment at <organization name>?

If yes, what is the date, time and appointment provider?

Date: Time: Provider:

Y N	Request a GFE without scheduling an appointment?

Reason for Visit (As specific as possible) :

At <Organization name> there are several programs available to patients to alleviate the cost of accessing healthcare. The amount that you will be pay is dependent on qualifying for these programs.

Expected Services and Estimated Costs (As of Today):

Services:	CPT Code:	Charges by Payment Group:				
This estimate is based on services needed at time of scheduling and can change if additional services are provided.		Sliding Fee Scale:				Self-Pay:
		A	B	C	D	E

Expected Diagnoses for Visit:	Diagnosis codes unavailable at time of scheduling? Y N
ICD-10 Code	Description:

Note: This Good Faith Estimate is based on your stated needs, conditions and payment sources at time of scheduling. This estimate is subject to change based on services provided. If your actual charges exceed $400 of this estimate, you qualify to dispute the charges with patient financial services. If you choose to dispute charges, there will be no effect on the quality or availability of your care at <organization name>. This form is intended to be an estimate and is not a bill, statement or receipt.