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NO SURPRISES ACT Good Faith Estimate
Covered & Non-Covered Service Waiver Form for ACTIVE TREATMENT PHASE

Introduction:

This Good Faith Estimate of Covered & Non-Covered Service Waiver Form is for your ACTIVE TREATMENT PHASE and is being provided to you specifically to allow to understand what your financial responsibility will be for items and/or services. This includes items and/or services that our office believes will **not** be covered by your healthcare carrier. Upon verification of benefits either online or via telephone with your healthcare carrier it is our understanding that the items and/or services checked off below are **not** going to be covered when performed in this office by our providers.

Our office call

In or Out of Network

Our providers are ☐ IN NETWORK ☐ OUT OF NETWORK with your health carrier.

Our office is ☐ IN NETWORK ☐ OUT OF NETWORK with your health carrier.

For OUT OF NETWORK, **we are not required to submit claims.**

Our office ☐will ☐will not submit claims on your behalf.

Agreement and Understanding:

The amount listed with this form are only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. This means that the final cost of services may be different than this estimate.

Patient Call

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Your signature indicates your complete understanding of your financial obligation. This signature also acknowledges that our office has communicated to you our understanding of your health coverage and specifically that our office believes that the items and/or services checked off on page two will **not** be covered.

- Patient Name: _____ DOB: _____
- Primary Health Carrier: _____ ID#: _____
- Secondary Health Carrier: _____ ID#: _____

_____ _____
Signature of Patient Date

_____ _____
Legal Representative (if appl) - Printed Name Date

_____ _____
Legal Representative (if appl) – Signature Date

Items / Services

Expected Services	Service Code	Description	Estimated amount to be billed	Not covered by your carrier
☐	99202	New Patient Examination Level II	65.00	☐
☐	99203	New Patient Examination Level III	100.00	☐
☐	99204	New Patient Examination Level IV	130.00	☐
☐	99205	New Patient Examination Level V	150.00	☐
☐	99211	Established Patient Examination Level I	15.00	☐
☐	99212	Established Patient Examination Level II	20.00	☐
☐	99213	Established Patient Examination Level III	30.00	☐
☐	99214	Established Patient Examination Level IV	50.00	☐
☐	99215	Established Patient Examination Level V	80.00	☐
☐	98940	Chiropractic Manipulative Therapy 1-2 regions	65.00	☐
☐	98941	Chiropractic Manipulative Therapy 3-4 regions	75.00	☐
☐	98942	Chiropractic Manipulative Therapy 5 regions	90.00	☐
☐	97010	Hot or Cold Pack		☐
☐	97012	Traction, Mechanical	35.00	☐
☐	97014	Electric Stimulation, unattended		☐
☐	G0283	Electric Stimulation (not for wound care), unattended		☐
☐	97032	Electric Stimulation, attended	45.00	☐
☐	97035	Ultrasound		☐
☐	97039	Unlisted Modality _____		☐
☐	97110	Therapeutic Exercise @ 15 minutes	40.00	☐
☐	97112	Neuromuscular reeducation @ 15 minutes	42.00	☐
☐	97124	Massage @ 15 minutes		☐
☐	97139	Unlisted Therapeutic Procedure _____		☐
☐	97140	Manual Therapy Techniques @ 15 minutes	45.00	☐
☐				☐
☐				☐
☐				☐
☐				☐

VERIFICATION OF BENEFITS INFORMATION:

Your Benefit Year is ☐Calendar Year ☐From _____ to _____

COPAY: $_____ Co-Insurance: _____% Deductible: $_____ Out of Pocket: $_____

Maximum # of visits per benefit year _____ or ☐ N/A

Maximum amount of coverage per visit $ _____ or ☐ N/A

Referral required for coverage ☐YES ☐NO

Authorization required for coverage ☐YES ☐NO, if yes after ____ # of visits or ☐ N/A

Other coverage limitations: _____

I understand that the above information is not a guarantee of payment and is only what was conveyed by my insurance at the time of verification.

_____ _____

Signature of Patient Date

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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 [877-696-6775].

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [877-696-6775].

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.