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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 help you 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.

Patient Name: _____ **DOB:** _____

Primary Health Carrier: _____ **Secondary Health Carrier:** _____
ID# _____ **ID#** _____

In or Out of Network : 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** submit claims on your behalf.

Agreement and Understanding: The amounts listed with this form are only an estimate; this is not an offer or contract for services. This means that the final cost of services may be different than this estimate.

Patient is to CALL: Contact your health plan to find out how much, if any, your portion may be.

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 this page will **not** be covered.

VERIFICATION OF BENEFITS INFORMATION: Your Benefit Year is ____Calendar Year (or) ____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**

Expected Services	Service Code	Description	Estimated Amount	NO cover
	99202	New Patient Examination Level II	**65.00**	
	99203	New Patient Examination Level III	**100.00**	
	99204	New Patient Examination Level IV	**130.00**	
	99211	Established Patient Examination Level I	**15.00**	
	99212	Established Patient Examination Level II	**20.00**	
	99213	Established Patient Examination Level III	**30.00**	
	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**	
	97012	Traction, Mechanical	**35.00**	
	97032	Electric Stimulation, attended	**45.00**	
	97110	Therapeutic Exercise @ 15 minutes	**40.00**	
	97112	Neuromuscular reeducation @ 15 minutes	**42.00**	
	97140	Manual Therapy Techniques @ 15 minute	**45.00**	

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.

Date: _____
Printed Patient Name: _____
Signature of Patient: _____
Legal Rep. (if appl) – Printed Name: _____
Signature of Legal Rep.: _____

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.