Good Faith Estimate for Health Care Items and Services

Patient Full Name: _____ DOB: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Mobile: _____

City: _____ State: _____ Zip: _____

For Clinician Use Only:

Primary Diagnosis (if applicable): _____

Diagnosis code(s): _____

Secondary Diagnosis (if applicable): _____

Diagnosis code(s): _____

Date(s) of Service	Description	Service Code	Estimated amount to be billed

Estimate of what you may owe: $ _____

Provider Name: _____

Provider Signature: _____ Date: _____

NPI (if applicable) _____

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www.barringtonbhw.com

The estimated costs are valid for 12 months from the date of the Good Faith Estimate. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted 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 you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent or
Guardian Name: _____

Parent or
Guardian Signature: _____ Date: _____