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Description automatically generated**

**Good Faith Estimate - Hayes Physical Therapy**

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| **Date of Good Faith Estimate: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | | |
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| **Patient’s Information** | | |
| Name: Last | Middle | First |
| Date of Birth: / / | | |
| Street/P.O. Box |  | Apartment |
| City | State | Zip Code |
| Primary Phone Number: | | |
| Email Address: | | |
| Contact Preference: | [ ] Mail | [ ] Email1 [ ] Phone |
| **1** Emails could be sent over the open internet; no encryption provided | | |
| **Patient’s Diagnosis Information** | | |
| Primary Diagnosis (es):  Primary ICD-10 Code(s): |  |  |
| Other Diagnosis(es) |  | Associated ICD-10 Code(s)  2 |

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| [ ] Check this box if this service or item is not yet scheduled    If scheduled, list the date the Primary (Evaluative) Service or item that will  be provided: \_\_\_/\_\_\_/\_\_\_ **or**  [ ] Check this box when providing “recurring” treatments in episode of care  Choose one duration/frequency:  [ ] From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ **or**  [ ] For [ to ] visits over [ ] calendar days |
| |  |  | | --- | --- | |  | **Estimated Cost/Visit** | | **As Documented in the Plan of Care** |  | | **Laser Therapy Packages** |  | |  |  | | Buy 6, 10% Discount  [ ] 10 Minutes: $540.00 (SAVE $60.00)  [ ] 15 Minutes: $810.00 (SAVE $90.00)  [ ] 20 Minutes: $1080.00 (SAVE $120.00)  [ ] 30 Minutes: $1620.00 (SAVE $180.00)  [ ] 35 Minutes: $1890.00 (SAVE $210.00)  [ ] 40 Minutes: $2160.00 (SAVE $240.00)  Buy 12, 15% Discount  [ ] 10 Minutes: $1020.00 (SAVE $180.00)  [ ] 15 Minutes: $1530.00 (SAVE $270.00)  [ ] 20 Minutes: $2040.00 (SAVE $360.00)  [ ] 30 Minutes: $3060.00 (SAVE $540.00)  [ ] 35 Minutes: $3570.00 (SAVE $630.00)  [ ] 40 Minutes: $4080.00 (SAVE $720.00)  **Buy 18, 20% Discount**  **PATIENT RECOMMENDED**  [ ] **10 Minutes: $1440.00 (SAVE $360.00)**  [ ] **15 Minutes: $2160.00 (SAVE $540.00)**  [ ] **20 Minutes: $2880.00 (SAVE $720.00)**  [ ] **30 Minutes: $4320.00 (SAVE $1080.00)**  **[ ] 35 Minutes: $5040.00 (SAVE $1260.00)**  **[ ] 40 Minutes: $5760.00 (SAVE $1440.00)**  Buy 24, 25% Discount  [ ] 10 Minutes: $1800.00 (SAVE $600.00)  [ ] 15 Minutes: $2880.00 (SAVE $900.00)  [ ] 20 Minutes: $3600.00 (SAVE $1200.00)  [ ] 30 Minutes: $5400.00 (SAVE $1800.00)  [ ] 35 Minutes: $6300.00 (SAVE $2100.00)  [ ] 40 Minutes: $7200.00 (SAVE $2100.00)  Buy 30, 30% Discount  [ ] 10 Minutes: $2100.00 (SAVE $900.00)  [ ] 15 Minutes: $3150.00 (SAVE $1350.00)  [ ] 20 Minutes: $4200.00 (SAVE $1800.00)  [ ] 30 Minutes: $6300.00 (SAVE $2700.00)  [ ] 35 Minutes: $7350.00 (SAVE $3150.00)  [ ] 40 Minutes: $8400.00 (SAVE $3600.00)  **TOTAl Estimated Charges for Episode of Care $** | $540.00  $810.00  $1080.00  $1620.00  $1890.00  $2160.00  $1020.00  $1530.00  $2040.00  $3060.00  $3570.00  $4080.00  **$1440.00**  **$2160.00**  **$2880.00**  **$4320.00**  **$5040.00**  **$5760.00**  $1800.00  $2880.00  $3600.00  $5400.00  $6300.00  $7200.00  $2100.00  $3150.00  $4200.00  $6300.00  $7350.00  $8400.00 | |
| **Practice/Facility/Provider Information** |
| Practice/Facility Legal Name: Hayes Physical Therapy |
| Practice/Facility Tax ID #: 232992442 |
| Practice/Facility NPI:1356540041 |
| Contact Person: Michele Mallon Phone: 610-695-9913 |
| Address: 195 W Lancaster Ave. Suite 3 |
| City: Paoli State: PA Zip Code: 19301 |
| Phone Number: 610-695-9913 Fax Number: 610-695-9746 |
| Practice Email Address: christinehayespt@gmail.com |
| Name of Therapist of Record:  Title: [ ] Physical Therapist |
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| **Disclaimers:** |
| * The Good Faith Estimate is an estimate and subject to change. |
| * There may be additional items or services not contained in good faith estimate. |
| * The patient has the right to initiate the patient-provider dispute resolution process. |
| * The Good Faith Estimate is not a contract, and the patient is not bound to services listed. |

**Please Review Page 5**

**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](http://www.cms.gov/nosurprises) or call [HHS PHONE NUMBER].

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call [HHS NUMBER].

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.