Good Faith Estimate - Hayes Physical Therapy

Date of Good Faith Estimate: __________/_________/_________			
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	[ ] Email[1]	[ ] 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) 2		Associated ICD-10 Code(s)	

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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

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

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.

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• 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 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 or call [HHS NUMBER].

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Keep a copy of this Good Faith Estimate in a safe place or ta