RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES UNDER THE "NO SURPRISES ACT"

Effective 01/01/2022

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a "Good Faith Estimate" explaining how much your medical and health care will cost.
- Health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including speech therapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (720) 845-6600.

GOOD FAITH ESTIMATE

Welcome and thank you for choosing MemoryCare Corporation for your **[speech-language pathology/occupational therapy/physical therapy needs].** As a self-pay client, you are entitled to a good faith estimate which outlines the potential costs associated with your evaluation and treatment.

The good faith estimate below is based on a suggested treatment plan for you. This treatment plan may change during our time together and you are entitled to an updated good faith estimate at any time. The information provided in this estimate, and any subsequent estimate, is only an estimate and actual items, services, and charges may be different. At any point during treatment, you have the right to engage in dispute resolution if the actual costs of services significantly exceed those listed in the below estimate. This estimate does not obligate you to continue treatment or obtain any of the listed services from MemoryCare Corporation.

PATIENT:	**DOB:**
DESCRIPTION OF SERVICE(S) TO BE PROVIDED:	
PRIMARY DIAGNOSIS:	**ICD-10 CODE:**
SECONDARY DIAGNOSIS (if applicable)**:**	**ICD-10 CODE:**

CPT® OR HCPCS CODES FOR EXPECTED SERVICES ***(Note:*** *Not every code will be charged at every visit)*

CODE	DESCRIPTION	COST ($)
92523	Comprehensive speech and language evaluation	
92507	Speech and language treatment	

Based on your plan of care and depending on **[list applicable factors]**, you will need between **[# of visits]** and **[# of visits]** visits this year, including any necessary evaluation(s) or re-evaluation(s). At **[$]** per visit, the estimated total costs are between **[# of visits multiplied by $ rate per visit]** and **[# of visits multiplied by $ rate per visit]**.

This good faith estimate lists services that will be furnished at **[clinic/telehealth/home]** and applies to all providers in this practice, including the initiating provider: **[insert provider name, credentials, NPI, and tax ID]**.

By signing this document, you acknowledge that you have received and understand your financial responsibilities to this practice if you choose to receive services. If you would like to seek reimbursement from your health insurance, we can provide a superbill at the end of your visit(s). Please note that our rates may be different from your insurance reimbursement rate and reimbursement rates could be lower. We recommend that you check with your insurance provider for rates and coverage of services.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-877-696-6775.

Patient Signature **Date**