Good Faith Estimate for Recurring Services

Date of Estimate: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert DOB]

Provider Information

Provider Name: [Insert Name/Business Name]
Tax ID / NPI: [Insert ID Number]
Address: [Insert Business Address]
Contact: [Insert Phone/Email]

Description of Recurring Services

This estimate is for a recurring course of treatment. The services listed below are expected to be provided regularly for the duration of the treatment plan.

Service/CPT Code	Description	Frequency	Estimated Cost per Session
[Insert Code]	[Insert Description]	[e.g., Weekly]	$[0.00]
[Insert Code]	[Insert Description]	[e.g., Monthly]	$[0.00]

Estimated Total Cost for [Insert Duration, e.g., 6 Months]: $[0.00]

Important Disclaimers

- 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 you are billed for more than this Good Faith Estimate (at least $400 more than the estimate), you have the right to dispute the bill.
- You may contact the health care provider listed above 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 of the date on the original bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Provider Signature: _____