Date: [Date]

Patient Name: [Patient Name]
Patient Date of Birth: [Date of Birth]
Estimate Reference Number: [Reference Number]

Subject: Confirmation of Receipt and Signature - Good Faith Estimate

Dear [Patient Name],

This letter serves as formal confirmation that [Provider/Facility Name] has received your signed Good Faith Estimate (GFE) for the following scheduled services:

Scheduled Service(s): [Description of Services]
Scheduled Date: [Date of Service]
Estimated Total Cost: $[Amount]

By signing the Good Faith Estimate on [Date Signed], you acknowledge that you have been informed of the expected costs for these healthcare items and services. Please keep a copy of the signed estimate for your records.

Important Information regarding your estimate:

- The Good Faith Estimate is only an estimate and actual costs may differ.
- This estimate does not include unknown or unexpected costs that may arise during treatment.
- If your final bill is at least $400 more than this estimate, you have the right to initiate a patient-provider dispute resolution process.

If you have any questions regarding this estimate or your upcoming appointment, please contact our billing office at [Phone Number] or [Email Address].

Sincerely,

[Name of Staff/Department]
[Provider/Facility Name]