GOOD FAITH ESTMATE FOR HEALTH CARE SERVICES

The following is a list of expected charges for _____, scheduled for _____.

The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Date | Patient Name

Patient Date of Birth | Patient Identification Number

Home Phone | Cell Phone | Email Address

Address

City | State | ZIP Code

Patient Contact Preference (Mail/Email/Phone)

Primary Service or Item Requested/Scheduled

Patient Primary Diagnosis | Primary Diagnosis Code

Patient Secondary Diagnosis | Secondary Diagnosis Code

If scheduled, date of primary service | Date of Good Faith Estimate

Estimated Total Cost: _____

Dr. Helbing Allergy & Asthma Associates

Amir Shahlaee, MD _____