Axis Physical Therapy Inc – 21009 76TH Ave W – Edmonds, WA 98026
Good Faith Estimate for Health Care Items and Services

Patient Information							
First Name		Middle Name		Last Name			
Date of Birth		Identification #					
Address							
City		State		Zip			
Email Address							
Patient Contact Preference	☐	By Mail	☐	By Email	☐	By Phone	

Patient Diagnosis							
Primary Service or Item Requested/Scheduled:	Physical Therapy Evaluation & Treatment						
Patient Primary Diagnosis		Primary Diagnosis Code					
Patient Secondary Diagnosis		Secondary Diagnosis Code					
If scheduled, list the date(s) the Primary Service or Item will be provided:							
Date		or	From Date:		To Date:		
☐	Check this box if the service or item is not yet scheduled.						

Convening Provider/Facility					
Provider Facility Legal Name	**Axis Physical Therapy Inc**	Provider Type	**Physical Therapy**		
Street Address Where Services Are To Be Performed:					
Address 1	**21009 76th Ave W**				
City	**Edmonds**	State	**WA**	Zip	**98026-7105**
Contact	**Reception or Billing**	Phone	**425-672-2910**	Email	**clientservices@axisptinc.com**
National Provider ID **1205864816**		Taxpayer ID # **20-4823679**			

Axis Physical Therapy Inc – 21009 76TH Ave W – Edmonds, WA 98026
Good Faith Estimate for Health Care Items and Services

Details of Services and Items for Convening Provider/Facility						
Service/Item	Address where service/item will be provided.	Diagnosis Code	Service Code	Quantity	Expected Cost	Actual Cost (Office Use)
	Street, City, St, Zip	ICD Code	Service Code Type: Service Code Number			
Physical Therapy Evaluation	21009 76th Ave W, Edmonds, WA 98026	TBD @ time of Evaluation	97164 CR EVAL	1	$300.00	
PT follow-up Visit	21009 76th Ave W, Edmonds, WA 98026		97110 CR LAND 97113 CR AQUATIC		$150.00 $200.00	
Total Expected Charges from Convening Provider/Facility					$	

Additional Health Care Convening Provider/Facility Notes:

The following is a detailed list of expected charges for PHYSICAL THERAPY SERVICES scheduled for DATE[S] OF SERVICE: PT EVALUATION:____/____/20___,

PT FOLLOW-UP APPOINMENTS (TBD) or if scheduled: ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, ____/____/____, and ____/____/____
(may attach printed appointment list when patient schedules and scan with this document), as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care]. [Include if items or services are reoccurring.]
"The estimated costs are valid for 12 months from the date of the Good Faith Estimate."

Date of Good Faith Estimate:	_____/_____/20___

Summary of Expected Charges

Convening Provider/Facility: PT EVALUATION @ $300/Evaluation	$	
Convening Provider/Facility: FOLLOW-UP VISITS @ $150/$200 visit (each date of service)	$	
Convening Provider/Facility: Additional items/services description:	$	
Total Estimated Cost:	$	

Axis Physical Therapy Inc – 21009 76TH Ave W – Edmonds, WA 98026
Good Faith Estimate for Health Care Items and Services

Disclaimer

THIS IS NOT A CONTRACT AND YOU ARE NOT OBLIGATED TO HAVE THE SERVICES LISTED.

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 this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may 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.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity 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/consumers or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.
You may need it if you are billed at a higher amount than this Good Faith Estimate.

Patient Signature (not required):	
Signature of Personal Representative:	
Relationship:	
Date:	