



**Total Patient Estimated Amount:** \_\_\_\_\_

All costs are due at the time of service. PHC does offer payment plans, as we want to ensure our patients receive the care they need with the ability to work with the Finance Department on payment structure.

**Disclaimers:**

PHC has tried to estimate the coding and the value attached based on the information provided at time of scheduling. PHC cannot always predict how each visit will be billed. So, by providing this estimate we disclose that we have tried our best to provide the patient with the total estimated cost of the appointment. *It will be the patient's responsibility to pay any additional cost above this estimate.*

Please be aware that the Good Faith Estimate provided to you includes the anticipated costs for the items and services listed. However, there may be additional items or services recommended by your convening provider or convening facility as part of your course of care. These additional items or services must be scheduled or requested separately and are not reflected in this estimate. For a comprehensive understanding of your potential costs, please discuss with your provider or facility.

The Good Faith Estimate provided to you is not a contract. It does not obligate you, as an uninsured (or self-pay) individual, to obtain the items or services from any of the providers or facilities listed in the estimate. You are free to seek care from any provider or facility of your choice.

If you have been billed more than \$400 over the amount on this GFE, contact the Promise Billing department at 217-403-5403. 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. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider, you will have to pay the higher amount. To start the dispute process, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call HHS at 312-353-5160.

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

Signed by Promise Healthcare Representative: \_\_\_\_\_

Signed Date: \_\_\_\_\_

GFE provided to patient via: Email  US Mail  Via Hand On  \_\_\_\_\_ # of days before scheduled appt.

Copy sent to Medical Records Department: