Promise Healthcare

GOOD FAITH ESTIMATE

Medical

819 Bloomington Rd. Champaign, Il 61820

Date of Good Faith Estimate: _____

If scheduled, list the date(s) the Primary Service or Item will be provided:_____
What Provider is the Primary Service or Item scheduled with: _____
Provider NPI:_____
Check this box if this Service or Item is not yet scheduled. ☐

Patient Name:_____DOB:_____Med Rec #: _____
Address:_____City:_____State:_____Zip_____

This information provided by Promise Healthcare (PHC) Good Faith Estimate (GFE) is an estimate of potential charges when a patient is seen at our clinic. All medical providers use a set of codes (CPT codes) established by the government to determine the complexity and value of an office visit or procedure. These codes may vary based on the type of visit occurring.

X	Service	Code	Full Fee	Discounted Fee
	New Pt Office Visit	99205	$415.00	
	Est Pt Office Visit	99215	330.00	
	Glucose Blood	82962	$35.00	
	Urinalysis	81002	$31.00	
	Est. Well Visit	99397	$249.00	
	New Well Visit	99387	$297.00	
	Psychiatric w/meds	90792	$540.00	
	Depo Provera	J1050	$47.51	
	Mirena		$421.29	
	Covid vaccine	91320	$131.10	
	Flu vaccine	90661	$40.00	
	Other			

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 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: