OMB Control Number: 0938-1433
Expiration Date: 11/30/2027

Right to Receive a Good Faith Estimate of Expected Charges

Notice for Uninsured and Self-Pay Patients — Under the No Surprises Act

You have the right to receive a Good Faith Estimate explaining how much your physical therapy care is expected to cost.

Under federal law, health care providers must give patients who don't have health insurance, or who are not using their health insurance for a visit, a written estimate of expected charges before items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services, upon request or when you schedule care. This includes related costs such as evaluations, treatment sessions, and any durable medical equipment.
- If you schedule an item or service at least 10 business days in advance, your provider must give you a Good Faith Estimate in writing within 3 business days of scheduling.
- If you schedule at least 3 business days in advance, you must receive it within 1 business day of scheduling.
- You can also ask any provider for a Good Faith Estimate before you schedule an item or service. If you do, you must receive it in writing within 3 business days of your request.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you have the right to dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. You may need it if you are billed a higher amount.
- For questions or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises** or call 1-800-985-3059.

Highbar Physical Therapy provides care at clinic locations across Massachusetts and Rhode Island under Highbar Physical Therapy and affiliated brands, JVPT, Peak Physical Therapy and Sports Performance, and Physical Therapy U brands. This GFE notice applies to all our locations.

Page 1 of this document to be posted in visible area at all brand locations

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Physical Therapy U

(A Highbar Affiliated Brand)

Good Faith Estimate for Health Care Items and Services - Form

Self-Pay and/or Uninsured

About This Estimate

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time it was created.

- This Good Faith Estimate is not a bill, and it is not a contract. It does not require you to obtain any of the listed items or services from Highbar Physical Therapy or any provider named on it.
- It does not include any unknown or unexpected costs that may arise during treatment — for example, complications or additional services. You could be charged more if this happens.
- Additional items or services that your provider recommends as part of your course of care, but that are not included in this estimate, must be scheduled or requested separately. Ask your Patient Care Coordinator for a Good Faith Estimate covering those items or services.
- If you are billed $400 or more above this Good Faith Estimate, you have the right to dispute the bill.
- You may contact us directly to ask us to update the bill to match the estimate, negotiate the bill, or to ask about financial assistance.
- You may also start a Patient-Provider Dispute Resolution process with the U.S. Department of Health and Human Services (HHS). You must start this process within 120 calendar days (about 4 months) of the date on your original bill. There is a $25 fee to use the process. If the reviewing agency agrees with you, you will pay the amount on this Good Faith Estimate (less the fee). If it agrees with us, you will pay the higher billed amount.
- To learn more or to start a dispute, visit **www.cms.gov/nosurprises** or call 1-800-985-3059.
- 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. You may also request a copy of any Good Faith Estimate we issued you within the last 6 years at any time.

Patient Information

Patient First Name, Middle Name, Last Name:

Patient Date of Birth:

Patient Identification Number:

Street Address or PO Box, Apartment:

City, State, ZIP Code:

Phone:

Email Address:

Patient's Contact Preference: ☐ By mail ☐ By email

Patient Diagnosis

Primary Service or Item Requested/Scheduled:

Patient Primary Diagnosis:

Primary Diagnosis Code (ICD-10):

Patient Secondary Diagnosis:

Secondary Diagnosis Code (ICD-10):

If scheduled, list the date(s) below. ☐ Not yet scheduled

Scheduled Date(s):

Date of Good Faith Estimate:

Summary of Expected Charges

Provider / Facility: Physical Therapy U (A Highbar affiliated brand)

Rendering Provider Name(s) and Credentials:

NPI (National Provider Identifier):

Tax Identification Number (TIN):

Service Location (clinic address):

Item / Service (CPT/HCPCS code)	Expected Charge
Initial Evaluation (CPT 97161, 97162, or 97163)	$150.00
PT Follow-up Visit (typical codes may include CPT 97110, 97112, 97116, 97140, 97530, 97535, and other therapeutic modalities as clinically indicated)	$100 per visit

Estimated total cost by treatment frequency, based on an 8-week plan of care following the initial evaluation:

Visit Frequency	Estimated Total Cost (after evaluation)
2x a week for 8 weeks	**$1,600**
3x a week for 8 weeks	**$2,400**
4x a week for 8 weeks	**$3,200**

Items or services this provider expects may be recommended as part of your care, but that must be scheduled or requested separately (see "About This Estimate" above): re-evaluation visits, durable medical equipment, and any referrals to outside providers.

Total Estimated Cost Based on Treatment Plan Selected + Eval ($):

(Given by Clinical PT or Patient Care Coordinator)