GOOD FAITH ESTIMATE
Patient Request

Patient Name: _____ Patient ID: _____

Date of Request: _____ Insurance: _____

Patient's Preferred Method of Communications: Portal: _____ Email: _____ US Mail: _____

Patients choosing Email must initial here indicating they understand this is not a HIPAA approved method and they authorize email as a communication method: _____

US Mail posted as of the 5 day limit is deemed to be delivered within the required timeframe.

Attach a copy of the JWM Order to this form.

A copy of this request must be emailed to GoodFaithEstimate@jwmneuro.com by the patient or office staff so JWM's Business Office can complete the request timely.

Patient acknowledges:

- ☐ This is a Good Faith Estimate and not a binding agreement.
- ☐ This estimate does not include an estimate of patient out of pocket expenses such as deductibles, co-insurance, uncovered services or services performed by a non-JWM Neurology provider.
- ☐ The price the practices charges the patient may vary from the Good Faith Estimate based on the patient's medical needs.
- ☐ This Good Faith Estimate is valid for 30 days.
- ☐ JWM Neurology will make best efforts to respond to this request within 5 business days.

_____ _____

Patient Signature Date

This is your Good Faith Estimate from JWM Neurology PC as requested.

For Office Use				
CPT	**Description**	**Units**	**Per Unit Price**	**Extended Price**
Good Faith Estimate Total				

Date Good Faith Estimate was provided to patient: _____

JWM Neurology staff signature: _____