



## Focus on Function

### Good Faith Estimate for Health Care Items and Services

<b>Patient (First, MI, Last):</b>		
Date of Birth:	Patient Identification Number:	
<b>Patient Mailing Address, Phone Number, and Email Address</b>		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: <input type="checkbox"/> By mail <input type="checkbox"/> By email		
<b>Patient Diagnosis</b>		
Primary Service		
Patient Primary Diagnosis		
Patient Secondary Diagnosis		

If scheduled, list the date(s) the Primary Service will be provided:

[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate:

**Summary of Expected Charges**

(See the itemized estimate attached for more detail.)

Provider Name	Estimated Total Cost
---------------	----------------------

Provider Name	Estimated Total Cost
---------------	----------------------

Provider Name	Estimated Total Cost
---------------	----------------------

**Total Estimated Cost: \$**

The following is a detailed list of expected charges for \_\_\_\_\_, scheduled for \_\_\_\_\_. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

**(PT) Estimate**

Provider Name		Provider Type
		Physical Therapist
Street Address		
6400 N Santa Fe Ave. Suite B		
City	State	ZIP Code
Oklahoma City	Oklahoma	73116
Contact Person	Phone	Email
Kim Cryer	405-840-2903	kimcryer@focusonfunction.com
National Provider Identifier		Taxpayer Identification Number
		73-1570567

**Details of Services and Items for PT**

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Physical therapy evaluation: low complexity (occ)			97161		
Physical therapy evaluation: moderate complexity (occ)			97162		
Physical therapy evaluation: high complexity (occ)			97163		
Gait Training to 1 or more areas; includes stair climbing. (each 15 min)			97116		
Therap. Activities; direct one on one patient contact by the provider (use of dynamic activities to improve functional			97530		

performance. (each 15 min)					
Therapeutic Exercises; 1 or more areas to develop, strength and endurance, ROM and flexibility. (Each 15 min )			97110		
Neuromuscular Re-Education of movement, balance, coordination, kinesthetic sense, posture& proprioception to 1 or more areas. (each 15 min)			97112		
Self Care/Home Mgt. Training direct 1 on 1 contact (e.g. ADL and compensatory training, meal prep, safety procedures and instructions of adaptive equipment.			97535		
Wheelchair management/propulsion training. Includes assessment, fitting, training. (each 15 min)			97542		

<b>Total Expected Charges from Physical Therapy \$_____</b>
Additional Health Care Provider/Facility Notes

## (OT) Estimate

Provider Name		Provider Type Occupational Therapist	
Street Address 6400 N Santa Fe Ave. Suite B			
City Oklahoma City	State Oklahoma	ZIP Code 73116	
Contact Person Kim Cryer	Phone 405-840-2903	Email kimcryer@focusonfunction.com	
National Provider Identifier		Taxpayer Identification Number 73-1570567	

### Details of Services and Items for OT

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Occupational therapy evaluation, low complexity (occ)			97165		
Occupational therapy evaluation, moderate complexity (occ)			97166		
Occupational therapy evaluation, high complexity (occ)			97167		
Therap. Activities; direct one on one patient contact by the provider (use of dynamic activities to improve functional performance. (each 15 min)			97530		

Therapeutic Exercises; 1 or more areas to develop, strength and endurance, ROM and flexibility. (Each 15 min)			97110		
Neuromuscular Re-Education of movement, balance, coordination, kinesthetic sense, posture & proprioception to 1 or more areas. (each 15 min)			97112		
Self Care/Home Mgt. Training direct 1 on 1 contact (e.g. ADL and compensatory training, meal prep, safety procedures and instructions of adaptive equipment.			97535		
Wheelchair management/propulsion training. Includes assessment, fitting, training. (each 15 min)			97542		

<b>Total Expected Charges from Occupational Therapy \$_____</b>
Additional Health Care Provider/Facility Notes

## (ST) Estimate

Provider Name	Provider Type Speech Therapist	
Street Address 6400 N Santa Fe Ave. Suite B		
City Oklahoma City	State Oklahoma	ZIP Code 73116
Contact Person Kim Cryer	Phone 405-840-2903	Email kimcryer@focusonfunction.com
National Provider Identifier	Taxpayer Identification Number 73-1570567	

### Details of Services and Items for ST

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Speech Therapy Treatment. (occ)			92507		
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)			92523		
Dysphagia Treatment of swallowing dysfunction and/or oral function. (occ)			92526		
Clinical Evaluation of Swallow. (occ)			92610		

**Total Expected Charges from Speech Therapy \$ \_\_\_\_\_**

Additional Health Care Provider/Facility Notes



## **You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost**

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 405-840-2903.

***I have read and understand the Good Faith Estimate for the healthcare services listed***

---

Signature of Patient/Power of Attorney

Printed Name

Date