SPEECH SUPERSTARS
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Good Faith Estimate

Welcome and thank you for choosing Speech Superstars for your Speech Language Pathology needs. As a self-paying patient, you are entitled to a good faith estimate which outlines the potential costs associated with your child's evaluation and treatment in our office.

The good faith estimate below is based on a suggested treatment plan for your child. This treatment plan may change during our time together and you are entitled to an updated good faith estimate at any time. The information provided in this estimate is only an estimate; and actual items, services, and charges may be different. At any point during treatment, you have the right to engage in dispute resolution if the actual costs of services significantly exceed those listed in the below estimate.

This estimate does not obligate you to continue treatment or obtain any of the listed services from Speech Superstars.

PATIENT: _____ DOB: _____

DESCRIPTION OF SERVICE(S) TO BE PROVIDED: _____

PRIMARY DIAGNOSIS: ICD-10 CODE: _____

SECONDARY DIAGNOSIS (if applicable): ICD-10 CODE: _____

92523 Comprehensive speech and language evaluation

92507 Speech and language treatment

Sample estimate:
Based on your plan of care and depending on [list applicable factors] you will need between [# of visits] and [# of visits] visits this year, including any necessary evaluation(s) or re-evaluation(s). At [$] per visit, the estimated total costs are between [# of visits multiplied by $ rate per visit] and [# of visits multiplied by $ rate per visit].

This good faith estimate lists services that will be furnished at Speech Superstars and applies to all providers in this practice, including the initiating provider: [insert provider name, credentials, NPI, and tax ID].

By signing this document, you acknowledge that you have received and understand your financial responsibilities to this practice if you choose to receive services. If you would like to seek reimbursement from your health insurance, we can provide a superbill at the end of your visit(s). We recommend that you check with your insurance provider for coverage of services.

Parent Signature _____ Date _____