Peace Valley Internal Medicine, P.C.

Good Faith Estimate for Health Care Items and Services

Patient Name:____ Date of Birth: _______/_____/_____

Street Address: ____

City: ____________________________ State______________ Zipcode ________________

Telephone #_______________________ Email:______________________________________

Primary Service or Item Requested/Scheduled:____

Primary Diagnosis:____

Secondary Diagnosis:____

If scheduled, list the date of visit:____
Month Day Year

Provider Name____

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

Date of Good Faith Estimate:____
Month Day Year

Service /item - estimated cost:____

Service /item - estimated cost:____

Service /item - estimated cost:____

TOTAL ESTIMATED COST: $____