Good Faith Estimate & Billing Protections

Your right to an estimate

If you do not have health insurance or will not use it to pay for care, you generally have the right to a written Good Faith Estimate of expected charges for non-emergency services. You can ask for an estimate before deciding whether to schedule. Contact our client care team at (303) 770-6933.

When you receive your estimate

For care scheduled 3-9 business days in advance, we provide the estimate within 1 business day after scheduling. For care scheduled at least 10 business days in advance, we provide it within 3 business days after scheduling. If you request an estimate without scheduling, we provide it within 3 business days of the request. If care is scheduled fewer than 3 business days ahead, the federal advance-estimate requirement generally does not apply; you can still ask about expected charges.

What the estimate means

Your estimate reflects the services and charges reasonably expected based on information available when it is prepared. It is not a contract or a requirement to receive care. Unexpected services may lead to additional charges. Your provider will discuss changes in the planned services and update your estimate when required. Frequency and duration are individualized; this form does not assume 52 therapy visits or 18 medication visits for every client.

If your bill is higher than expected

If a bill from a provider is at least $400 above that provider's estimated charges, you may qualify for the federal patient-provider dispute resolution process. Start the process within 120 calendar days of the date on the initial bill. Keep a copy of your estimate and bill. For information, visit www.cms.gov/nosurprises or call (800) 985-3059. You will not be penalized for using the dispute process.

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Individual Good Faith Estimate

To be completed by the treating provider or office for the individual client. This blank worksheet is not itself a completed estimate.

Date prepared: _____ Estimate period: _____

Client name: _____ Date of birth: _____

Client contact / mailing address: _____

Treating provider / credential: _____

Provider NPI: _____ Tax ID: _____

Practice / facility NPI (if applicable): _____

Service location: 6000 Greenwood Plaza Blvd #105, Greenwood Village, CO 80111
or telehealth, as confirmed for the appointment.

Scheduled date(s) or expected frequency: _____

Service(s) requested: _____

Diagnosis / service codes, if known and applicable: _____

Do not assign a diagnosis solely to populate this form. Clinical information and codes must reflect the individual assessment and services.

Service / code	Expected dates / quantity	Charge per service	Expected total
Total expected charges			

Additional anticipated services, exclusions, or other providers (if known):

_____

_____

Questions about this estimate: Call (303) 770-6933.