Mitchell Physical Therapy

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number: NA		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: ☐ By mail ☐ By email		
Patient Diagnosis (optional)		
Primary Service or Item Requested/Scheduled Initial Evaluation + follow up visits		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code