Good Faith Estimate Template for Audiology Services

Welcome and thank you for choosing **The University of Nebraska-Lincoln Speech-Language and Hearing Clinic** for your audiology needs. As a self-pay or commercially insured patient, you are entitled to a good faith estimate, which outlines the potential costs associated with your evaluation and treatment in our office.

The good faith estimate below is based on a suggested treatment plan for you. 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, and any subsequent 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 by a minimum of $400.

This estimate does not obligate you to continue treatment or obtain any of the listed services from **The University of Nebraska-Lincoln Speech-Language and Hearing Clinic.**

PATIENT:	**DOB:**
DESCRIPTION OF SERVICE(S) TO BE PROVIDED: Evaluation VRA (6 months to 3 years)	
PRIMARY DIAGNOSIS:	**ICD-10 CODE:**
SECONDARY DIAGNOSIS (if applicable)**:**	**ICD-10 CODE:**

CPT® OR HCPCS CODES FOR EXPECTED SERVICES ***(Note:*** *Not every code will be charged at every visit)*

CODE	DESCRIPTION	COST ($)
92579	Visual reinforcement audiometry (VRA)	$95.00
92550	Tympanometry and reflex threshold measurements	$70.00
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	$65.00

This good faith estimate lists services that will be furnished at **The University of Nebraska-Lincoln Speech-Language and Hearing Clinic** 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). Please note that our rates may be different from your insurance reimbursement rate and reimbursement rates could be lower. We recommend that you check with your insurance provider for rates and coverage of services.

Patient Signature **Date**