COMPLETE CARE.

302.998.0300
www.entad.org

Welcome and thank you for choosing ENT & Allergy of Delaware for your Speech-Language Pathology/Therapy Services needs. As a self-pay 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 estimate below. This estimate does not obligate you to continue treatment or obtain any of the listed services from ENT & Allergy of Delaware.

Speech -Language Pathology/Therapy Services		
CODE	DESCRIPTION	COST ($)
92507	Speech Therapy	$111 per visit
92524	Voice Evaluation	$158
92526	Swallow Therapy	$122
92610	Swallow Evaluation	$123
92612	Endoscopic Swallowing Test	$287
31579	Videostrobe	$286

This good faith estimate lists services that will be furnished at ENT & Allergy of Delaware and applies to all providers in this practice.

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: _________________

Name: ____ DOB: _________________ Acct # ___________

PATIENT COPY