(Your Clinic name, address, and phone number here)

Good Faith Estimate for Health Care Items and Services, Dated __/__/20___

Patient's Full Name_____ DOB___/____/_____ Patient ID#(if any)_____

Patient Mailing Address, _____ Zip_____

Patient Phone Number (_____)_____

Email Address_____@_____Patient's Preferred Contact: [ ] mail [ ] email

Patient DiagnosisInformation: _____(Patient Primary and Secondary Diagnosis here)_____

Name of Primary Service Requested/Scheduled_____

Primary Diagnosis Code_____Treatment_____ CPT Code_____ Cost_____

Secondary Diagnosis (if any) Code_____ Treatment_____ CPT Code_____ Cost_____

If scheduled, list the datethe Primary Service or Item will be provided: ___ /___/20_____

( ) Check this box if this service is not yet scheduled, or, ( )(Additional scheduled dates may be attached

Summary of Expected Charges(there may be an itemized estimate attached with more detail.)

(Your Name, Clinic Name, NPI # and TIN# here)

Estimated Total Cost_____.

Required Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. This estimate is not a contract, nor does it bind you to use this office or these services.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Actual costs may differ, or additional treatment may be required. If this happens, federal law allows you to dispute (appeal) the bill, if you choose.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call [HHS PHONE NUMBER]. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [HHS NUMBER].

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

(To be used with Patients with multiple scheduled visits)

The following is a detailed list of expected charges for ___[Name of Patient]_____ currently scheduled:

	Primary Diagnosis	ICD10 Code	Treatment	CPT Code	Cost*	Date Scheduled
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

*The estimated costs are valid for 12 monthsfrom the date of the Good Faith Estimate.