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| Provider/Facility Name: Click or tap here to enter name.  Address: Click or tap here to enter location where services will be provided.  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_  National Provider Identifier(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax Identification Number: \_\_\_\_\_\_\_\_\_ |
| **Good Faith Estimate for Services**  This document is a cost estimate for how much you can expect to pay for your scheduled appointment at Click or tap here to enter name. You may also be receiving this document because you requested cost information before scheduling an appointment. |
| **Patient Information**  Last Name, First Name and Middle Initial  Click or tap here to enter text.  Date of Birth: MM/DD/YYYY Patient ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Status:  Self-pay  Other: Click or tap here to enter text. |
| Your health care costs depend on factors like whether you have health insurance, your income and family size, and the services you are looking to receive. Our staff will help you determine which Sliding Fee Scale (SFS) payment group you belong to. The below cost estimate may change when Click or tap here to enter name. confirms your SFS Payment Group, or if your household income has recently changed.   |  |  | | --- | --- | | SFS Payment Group: \_\_\_\_\_\_\_\_\_\_ | Unknown | | *See* ***Appendix A*** *for information on how*  Click or tap here to enter name. *determines SFS payment groups* | *The cost estimates below do not include any discounts. You may be eligible for a discount that will lower your costs.* | |
| **Services Scheduled or Requested**  Service Description: Click or tap here to enter text.  Scheduled Date of Service: MM/DD/YYYY  Service has not been scheduled   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Click or tap here to enter text. | **Service Description (Code)** | **Diagnosis Code\*** | **Retail Cost** | **Discounted Cost** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | **Total Estimated Costs\*\* from** Click or tap here to enter text. | | |  |  |   \*Click or tap here to enter text. may not know the diagnosis code(s) for your visit yet.  \*\*Estimated costs are valid for one year from the Good Faith Estimate date.  Additional providers or facilities are expected to provide services or items as part of this visit. These additional cost estimates are on **Page 2**.  You may need additional services that require separate scheduling. See notes on **Page 2**. |
| **For Internal Use**  Does the patient require confidential services?  Yes  No  **Contact Preference – Deliver Good Faith Estimate by:**  Mailing address on file  Email/patient portal  Phone/text  Other mailing address: Click or tap here to enter text.  **Do not contact** |

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| **Good Faith Estimates for Additional Providers or Facilities**  If the below section is completed, there may be additional costs for your visit from another provider or facility.  Co-Provider/Co-Facility 1 Name: Click or tap here to enter name.  Address: Click or tap here to enter location where services will be provided.  City: Click or tap here to enter text. State: \_\_ Zip Code: \_\_  National Provider Identifier(s): \_\_\_\_\_\_\_\_\_ Tax Identification Number: \_\_\_\_\_\_\_\_\_   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Click or tap here to enter name. | **Service Description (Code)** | **Diagnosis Code\*** | **Retail Cost** | **Discounted Cost** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | **Total Estimated Costs\*\* from** Click or tap here to enter name. | | |  |  |   Co-Provider/Co-Facility 2 Name: Click or tap here to enter name.  Address: Click or tap here to enter location where services will be provided.  City: Click or tap here to enter text. State: \_\_ Zip Code: \_\_  National Provider Identifier(s): \_\_\_\_\_\_\_\_\_ Tax Identification Number: \_\_\_\_\_\_\_\_\_   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Click or tap here to enter name. | **Service Description (Code)** | **Diagnosis Code\*** | **Retail Cost** | **Discounted Cost** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | **Total Estimated Costs\*\* from** Click or tap here to enter name. | | |  |  |   \*Co-Provider/Co-Facility may not know the diagnosis code(s) for your visit yet.  \*\*Estimated costs are valid for one year from the Good Faith Estimate date. |
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| **Notes about additional services or items that** Click or tap here to enter name. **anticipates will require separate scheduling and may have additional costs:** |

**Good Faith Estimate Disclaimer**

Under Section 2799B-6 of the Public Health Service Act, Click or tap here to enter name. is required to provide a **Good Faith Estimate** of expected health care costs to individuals who are not enrolled in a health insurance plan or do not wish to use their health insurance coverage.

This Good Faith Estimate details the costs of services and items that are expected for the appointment you scheduled (or may schedule in the future), as documented in this agreement. Estimated costs are based on information known by Click or tap here to enter name. at the time the estimate was created. This Good Faith Estimate does not include additional, related services and items that may require separate scheduling or need to be requested separately.

The Good Faith Estimate does not include any unknown or unexpected costs. There may be additional charges if complications or special circumstances occur during your visit. If this happens, federal law allows you to dispute the bill using a dispute process.

This Good Faith Estimate is not a contract and does not require you to obtain services or items from Click or tap here to enter name. or any of the other providers or facilities listed on this document.

**If you have question about this Good Faith Estimate:**

► **Contact** Click or tap here to enter name.**:** Contact Click or tap here to enter name. to explain this estimate and answer any questions. They also can connect you with certain programs that may reduce or cover the cost of your health care.

► **If you have health insurance, call your health insurance plan**. Your plan may have better information about how much you’ll be asked to pay. You also can ask about what’s covered under your plan and your provider options.

**Right to Dispute Additional Charges**

If you have questions or concerns about your bill, please contact Click or tap here to enter name. at Click or tap here to enter name. and let them know your bill is higher than the amount in the Good Faith Estimate. They can answer questions about any differences and determine if your bill can be adjusted to align with the original Good Faith Estimate.

If your bill is more than $400 above the original Good Faith Estimate, you have the right to dispute charges by starting a **provider-patient dispute resolution process**. If you choose to use the dispute resolution process, you must start it within 120 calendar days (about 4 months) of the date on your original bill from Click or tap here to enter name.. There is a $25 fee.

If the agency reviewing your dispute…

► **Agrees with you:** You will have to pay the price on this Good Faith Estimate.

► **Disagrees with you:** You will owe the higher amount on your bill.

Starting a dispute resolution process will not reduce the quality of health services you receive at Click or tap here to enter name..

**For more information about your rights and protections**   
or to start a dispute resolution process, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers)   
or call 1-800-985-3059.

**Acknowledgement**

With my signature, I acknowledge the receipt of a Good Faith Estimate from [Provider/Facility Name]. I further acknowledge that I understand the information provided to me in this Good Faith Estimate, including cost estimates for services and my rights and protections. This is not a contract.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MM/DD/YYYY

Signature of patient or parent/guardian Date

Click or tap here to enter name. Click or tap here to enter name.

Name of patient or parent/guardian (printed) Relationship to patient