Initial Good Faith Estimate

Client Name: ____ Date of Birth:________________________

Primary Service or Item Requested/Scheduled: Initial Evaluation ____________________________

Patient Primary Diagnosis/Diagnosis Code: Unknown ____________________________________

Patient Secondary Diagnosis/Diagnosis Code: Unknown __________________________________

If scheduled, list the date(s) the Primary Service or Item will be provided: __________________________

Provider Name: _______________________ Estimated Total Cost: ________________________________

TOTAL ESTIMATED COST: $________________

The following is a detailed list of expected charges for an initial evaluation, scheduled for _____________ ___. An updated Good Faith Estimate will be provided following the initial evaluation for any further or recurring services.

Provider/Facility Name: ____________________ Provider/Facility Type:___________________________

Street Address: ____

City: __________________________________State: _________________ZIP: ______________________

Contact Person Phone: ______________________ Email: _______________________________________

National Provider Identifier: __________________ Taxpayer Identification Number: _________________

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Initial Evaluation				1	$

Total Expected Charges $_____________________

Additional Provider/Facility Notes: ____

Disclaimer

The Good Faith Estimate is not a contract and does not require the uninsured or self-pay individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

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. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. The information provided in the Good Faith Estimate is only an estimate of items or services reasonably expected to be furnished at the time the Good Faith Estimate is and actual charges may differ. There may be additional items or services the convening provider/facility recommends that must be scheduled or requested separately

You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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 1-877-696-6775.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775. 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.