



THE CENTER

For Counseling and Wellness

Good Faith Estimate for Health Care Items and Services

Patient Information		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box	Apartment/Unit	
City	State	Zip Code
Phone		
Email Address		
Patient Treatment Information		
Primary Service Requested/Scheduled		
Reason for Seeking Treatment		
Patient Primary Diagnosis (<i>If Known</i>)	Primary Diagnosis Code	
Patient Secondary Diagnosis (<i>If Known</i>)	Secondary Diagnosis Code	
If scheduled, list the date(s) the primary service will be provided:		
[] Check this box if this service is not yet scheduled		
Date of Good Faith Estimate: _____/_____/_____		
Provider name:	Estimated Total Cost:	
Total Estimated Cost: \$		

Disclaimer:

This Good Faith Estimate shows the costs of services that are reasonably expected for your health care needs for an item or service. The estimate is based on information at the time the estimate was created.

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. 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 842-279-2011.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 842-279-2011.

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.