YOUR PRACTICE NAME

Good Faith Estimate for Health Care Items and Services

Patient:		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: / /		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Address 1:		
Address 2:		
City:	State:	Zip:
Phone: ( ) -	Email:	
Patient's Contact Preference: ☐ By mail	☐ By email	☐ By phone

Patient Diagnosis:		
Patient Primary Diagnosis:		Primary Diagnosis Code:
Patient Secondary Diagnosis:		Secondary Diagnosis Code:
If scheduled, list the date(s) the Primary Service or Item will be provided: ☐ Check this box if this service or item is not yet scheduled		

Date of Good Faith Estimate: / /

Summary of Expected Charges
(See the itemized estimate attached for more detail.)

Estimated Total Cost: $	Estimated Total Cost: $
Estimated Total Cost: $	Estimated Total Cost: $
Estimated Total Cost: $	Estimated Total Cost: $
Total Estimated Cost: $	

The following is a detailed list of expected charges for Acupuncture Services, scheduled for as well as any items or services primary item or service as part of the period of care. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Should your treatment needs change, then the costs of services may increase or decrease. If needed, you will be provided an updated Good Faith Estimate to disclose those cost changes

Provider/Facility Name:		Provider/Facility Type:	
Street Address:			
City:		State:	ZIP Code:
Contact Person:	Phone: ( ) -	Email:	
National Provider Identifier:		Taxpayer Identification Number:	

Details of Services and Items:

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
Total Expected Charges:				**$**	
Additional Health Care Notes:					

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.

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, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may 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.

If you dispute your bill, the provider or facility cannot transfer that bill into collection or threaten to do so. If the bill has already moved into collection, then the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill. Disputing your bill and initiation of this process will not adversely impact the quality of care furnished to you.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.