

Good Faith Estimate

Individual estimate of expected health care charges

01 Patient and period of care

Patient full name

Date of birth (MM/DD/YYYY)

Estimate reference

Issue date

Request or scheduling date

Authorized representative, if applicable

Primary item or service requested or scheduled (plain-language description)

Appointment date(s), if scheduled

☐ Not yet scheduled

Period start

Period end (maximum 12 months)

Total expected number of sessions

Expected frequency

02 Primary provider or facility included

Provider or facility legal name

This provider or facility NPI

This provider or facility TIN

Treating professional and credentials; supervisor if applicable

State(s), modality and location(s) where services will be furnished

Itemized expected charges

Provider 1 | All amounts in United States dollars (USD)

Estimate reference

Patient name

Describe each anticipated service. Net rates must reflect applicable discounts. Fields do not calculate automatically; verify quantities and totals before delivery.

01 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

02 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

03 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

04 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

* Include diagnosis when determined and needed to calculate the estimate. If not determined or not needed for the calculation, state that; service codes and expected charges are still required.

Included discounts and other explanations

PROVIDER 1 TOTAL EXPECTED CHARGES \$

Estimate summary

Additional provider, if any, and estimate total (always complete the total)

Estimate reference

Patient name

☐ No additional provider is included in this estimate

Provider or facility legal name

This provider or facility NPI

This provider or facility TIN

State(s), modality and location(s) where services will be furnished

Contact person

Phone

Provider or facility type

01 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

02 Item or service

Service code / CPT

ICD, if applicable*

Quantity

Net rate \$

Expected charge \$

Location, modality and date(s) or period for this service

PROVIDER 2 TOTAL EXPECTED CHARGES \$

OTHER PROVIDERS IN ATTACHMENTS \$

Identify any attached sheets (provider and reference), or state none

TOTAL EXPECTED CHARGES \$

Include a provider's continuation sheets in that provider's subtotal. Estimate total = provider 1 + provider 2 + other providers in attachments. Complete the total even if there is only one provider.

Scope and your rights

Keep this document with all pages and attachments

Estimate reference

Patient name

Items or services to be scheduled separately

The items or services listed below are expected to require separate scheduling before or after the period covered. Separate Good Faith Estimates will be provided when they are scheduled or requested. Provider/facility names and identifiers, applicable diagnosis codes, service codes and expected charges will be included in those estimates. Use the contact instructions in the list to request each estimate; for our clinic's services, call 405-338-7674.

Item/service, provider if known, anticipated timing and request instructions; or state none

What this estimate means

This document reflects items, services and charges reasonably expected based on information available when it was prepared. Actual items, services or charges may differ; unexpected costs or special circumstances may arise. Additional recommended items or services requiring separate scheduling or requests are not included. **This estimate is not a contract and does not require you to receive care from any provider or facility listed.**

If your bill is higher than the estimate

If a provider or facility bills you **\$400 or more above** the total expected charges for that same provider or facility, you may qualify for the federal patient-provider dispute resolution process. You may ask the provider to correct the bill, negotiate the amount, or ask about financial assistance.

To start a federal dispute, submit the required notice within **120 calendar days after receiving the initial bill** with the disputed charges. Find instructions and the form at cms.gov/nosurprises/consumers or call **1-800-985-3059**. The current administrative fee is **\$25**. If the decision is in your favor, it is deducted from the amount you owe the provider. An independent reviewer determines the payment. Contacting the clinic does not replace filing a timely dispute.

During the dispute, the provider or facility cannot send the disputed bill to collections or threaten to do so; it must pause existing collection efforts and the accrual of late fees on unpaid amounts. It cannot retaliate or threaten retaliation.

Starting a dispute will not adversely affect the quality of your health care.

Keep your estimate and bills. You may ask the clinic for another copy. For help with this estimate, call 405-338-7674.

Prepared and reviewed by

Delivery date and requested format (paper / electronic)