

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who do not have insurance or are not using insurance** an estimate of the bill for services received.

*You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency item(s) or service. This includes costs like medical tests and other fees.

*Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item if possible. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item for service.

*If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

*Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

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, 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

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

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.

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Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	Zip Code
Phone Number		
Email Address		
Patient's Contact Preference <input type="checkbox"/> By Mail <input type="checkbox"/> By Email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
If scheduled, list the date(s) the Primary Service or Item will be provided:		
<input type="checkbox"/> Check this box if this service or item is not yet scheduled		
Date of Good Faith Estimate:		
Estimated Total Cost		
Provider Name	Estimated Total Cost <u>\$156</u>(first visit)	
Provider Name	Estimated Total Cost <u>\$128</u>(follow-ups)	
Provider Name	Estimated Total Cost	
Total Estimated Cost: \$		

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Good Faith Estimate for Health Care Items and Services

The following is a detailed list of expected charges for _____,
scheduled for _____. If the items or services are reoccurring, the
estimated costs are valid for 1 month from the date of the Good Faith Estimate.

Patient Signature _____ **Date** _____

Witness _____ **Date** _____