Good Faith Estimate and Financial Responsibility Notice

Date: [Date]

Patient Name: [Patient Name]

Patient Date of Birth: [DOB]

1. Good Faith Estimate

This notice provides an estimate of the costs for the healthcare items and services expected for your upcoming visit. This estimate is based on information known at the time the estimate was created.

Service Description: [Description of Services]

Estimated Total Cost: $[0.00]

Please note that this is only an estimate. Actual charges may vary depending on the specific care provided, complications, or additional services required during treatment.

2. Financial Responsibility

By signing this document, you acknowledge the following:

- You understand that you are responsible for the payment of all costs associated with the services rendered.
- If you have insurance, this estimate is based on your provider's understanding of your coverage. You are responsible for any deductibles, co-pays, or non-covered services determined by your insurance carrier.
- If you are self-pay or uninsured, you are responsible for the full estimated amount.

3. Right to Dispute

If you are uninsured or self-pay and receive a bill that is at least $400 more than this Good Faith Estimate, you have the right to dispute the bill through the patient-provider dispute resolution process.

Acknowledgment:

I have received this Good Faith Estimate and understand my financial responsibility for the services described above.

_____

Patient or Legal Representative Signature

_____

Date Signed