Good Faith Estimate

Date of Estimate: [Date]

Patient Name: [Patient First and Last Name]

Patient Date of Birth: [DOB]

Provider Information

Provider Name: [Doctor/NP/PA Name]
Clinic Name: [Practice Name]
Address: [Street Address, City, State, Zip]
Tax ID / NPI: [Provider Identifiers]

Estimated Services

Service Description	Service Code (CPT)	Estimated Cost
Primary Care Office Visit (Level [X])	[CPT Code]	$[Amount]
Preventive Exam / Wellness Visit	[CPT Code]	$[Amount]
In-Office Lab Testing (e.g., Blood Draw)	[CPT Code]	$[Amount]
Total Estimated Cost:		**$[Total Amount]**

Important Disclaimers

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for this visit.
- The estimate is based on information known at the time the estimate was created.
- Actual costs may vary depending on the clinical findings and any additional tests or services ordered during your visit.
- This estimate is not a contract and does not require you to obtain services from this provider.
- If your actual bill 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.

For questions regarding this estimate, please contact: [Billing Office Phone Number]