Good Faith Estimate for Health Care Items and Services

Date of Estimate: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]

Provider/Facility Name: [Insert Urgent Care Name]
Address: [Insert Address]

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.

Service/Item Description	Service Code (CPT/HCPCS)	Estimated Cost
Urgent Care Office Visit (Level [X])	[Insert Code]	$[0.00]
[Insert Additional Service, e.g., X-ray]	[Insert Code]	$[0.00]
[Insert Additional Service, e.g., Rapid Test]	[Insert Code]	$[0.00]
Estimated Total Cost		**$[0.00]**

Disclaimer:

- This Good Faith Estimate is only an estimate and the actual items, services, or charges may differ from this estimate.
- This estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or exceptional circumstances occur.
- You have the right to initiate a patient-provider dispute resolution process if the actual billed charges are at least $400 more than this Good Faith Estimate.
- This estimate is not a contract and does not require you to obtain the items or services from this provider.

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