Good Faith Estimate for Pediatric Wellness Exam

Date of Estimate: [Insert Date]

Patient Name: [Insert Child's Name]

Patient Date of Birth: [Insert Date of Birth]

This Good Faith Estimate explains the estimated cost of the pediatric wellness exam scheduled for [Date of Appointment]. This estimate is based on information known at the time the estimate was created.

Provider Information

Provider Name: [Insert Physician/Clinic Name]
Address: [Insert Street Address, City, State, Zip]
Tax ID / NPI: [Insert Identification Numbers]

Estimated Cost of Services

Service Description	Service Code (CPT)	Estimated Cost
Pediatric Wellness Exam (Preventive Visit)	[Insert Code, e.g., 99391-99395]	$[Insert Amount]
Standard Immunizations (Administration Fee)	[Insert Code]	$[Insert Amount]
Required Screenings (Vision/Hearing/Developmental)	[Insert Code]	$[Insert Amount]
Laboratory Services (Lead/Hemoglobin if applicable)	[Insert Code]	$[Insert Amount]
Total Estimated Cost:		**$[Insert Total Amount]**

Important Disclaimers

- This is only an estimate. Actual charges may vary depending on the patient's specific medical needs or additional tests ordered during the visit.
- This estimate does not include unknown or unexpected costs that may arise during treatment.
- If you 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.

- This estimate is not a contract and does not require you to obtain the services from this provider.

For questions regarding this estimate, please contact our billing department at [Insert Phone Number].