

NED ZALLIK, M.D., PLLC
GOOD FAITH ESTIMATE

Provider Name: _____ Provider Phone: _____

Provider Email: _____

Provider Address: _____

Provider NPI: _____ Practice FEIN: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient Email Address: _____

Patient Contact Preference (check one): _____ by mail _____ by email _____ by phone

Services	Diagnosis Code	Service CPT code(s)	Estimated Annual Cost
Membership Program Services: Those services listed as "Services" on Appendix 1 of that certain "Patient Agreement" executed by patient, as may be modified from time to time	TBD	TBD	-\$1,500 annually if patient is aged 16-29 -\$3,000 annually if patient is aged 30 or older

Estimated Primary Services Cost: \$1,500 or \$3,000 based on patient age.

The good faith estimate for additional items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care from additional providers (if any) is set forth in the attached, with an estimated cost "*Estimated Additional Services Cost*" of \$0.00.

Estimated Primary Services Cost plus Estimated Additional Services Cost = *Estimated Total Cost* of: \$1,500 or \$3,000 based on patient age.

The estimated costs are valid for twelve (12) months from the date of Good Faith Estimate.

Date Service or Item is Scheduled: _____ ☐ (***check if not yet scheduled***)

**Health Care Items/Services Expected to Be Separately Scheduled
with Another Provider or Facility**

For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility name and contact information for obtaining a good faith estimate

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, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

IF YOU ARE BILLED FOR MORE THAN THIS GOOD FAITH ESTIMATE, YOU MAY 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.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a \$25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the \$25 fee. If the SDR entity 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/consumers or call 1800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, or email at FederalIPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

A copy of this document was provided (check one) ☐ in person ☐ via email ☐ US mail ☐ other ☐ on _____, 20__.

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.

ADDITIONAL PROVIDER(S) GOOD FAITH ESTIMATE

Date of Good Faith Estimate: _____

Provider Name: _____ Provider Phone: _____

Provider Email: _____

Provider Address: _____

Provider NPI: _____ Practice NPI: _____ Practice FEIN: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient Email Address: _____

Patient Contact Preference (check one): ___ by mail ___ by email ___ by phone

Services	Diagnosis Code(s) (if determined)	Service CPT Code-	Quantity	Estimated Cost

Estimated Additional Services Cost: \$ _____