## GOOD FAITH ESTIMATE



## I. PATIENT INFORMATION

Name					
Date of Birth					
Account #					
Date of GFE					
Date of Service	check if not scheduled				
Provider Name					
	DEFEDENCE (DIEACE CHECK ONE AND INCLUDE ADDDECC)				
I. DELIVERY P	REFERENCE (PLEASE CHECK ONE AND INCLUDE ADDRESS)				
Mail	Address:				
Email	Address:				
II. SERVICE/PROVIDER INFORMATION  Name: ENT of Athens					
Location (check one)					
150 Nacoochee Street Athens, GA 306061					
8130 Macon Highway Athens, GA 30606					
Provider Name					
NPI					
Гах ID					

The following is a detailed list of expected charges for the scheduled/requested services. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

## GOOD FAITH ESTIMATE



Patient ID		Date	
CPT CODE	SERVICE DESCRIPTION	QUANTITY	COST
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
	TOTAL ESTIM	ATED COST	\$

For services provided with cost from other providers, additional copies of this page with their information will follow. *Total cost of service is the combined amounts listed on these pages and will be listed at the top of the Disclaimer on the final page.* 

## **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, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith Estimate, you 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. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency 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 or call 1-877-696-6775. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-877-696-6775. 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.