OMB Control Number [0938-XXXX]
Expiration Date [MM/DD/YYYY]

Inner Wisdom WELLNESS	**Name of Convening Provider or Convening Facility**	**Location**

Good Faith Estimate for Health Care Items and Services Under the No Surprises Act

Patient Information				
First Name	Middle Name	Last Name	Date of Birth	Patient Identification #

Patient Mailing Address, Phone Number, Email Address					
Street or PO Box	City	State	Zip	Patient Phone	Home ◉ Cell ○
Email Address			Patient's Contact Preference		
			By Mail ☐	By Email ☐	

PATIENT Diagnosis	
Primary **Service or Item** that is **Requested or Scheduled**	
Patient Primary Diagnosis	Primary Diagnosis Code
Patient Secondary Diagnosis	Secondary Diagnosis Code
If scheduled, list date(s) the Primary Service/Item to be provided:	☐ Check this box if this Service/Item is not yet scheduled
Date of Good Faith Estimate	
Provider #1 Name	Estimated Total Cost (auto populated): $ 0
Provider #2 Name	Estimated Total Cost:
Provider #3 Name	Estimated Total Cost:
Total Estimated Cost (All Providers) (auto populated)	$ 0
Summary of Additional Facility/Provider Notes:	

The following is a detailed list of expected charges for items/services: _____ scheduled for dates: _____ **IF SCHEDULED**]. [Include items or services that are recurring.]

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

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[Provider/Facility #1] Estimate			
Provider/Facility Name	Provider/Facility Type	National Provider Identifier (NPI)	Taxpayer ID Number

Street Address	City	State	Zip

Contact Person	Phone	Email

Details of Services & Items for [Provider/Facility #1]						
Service/Item	**Address Where it will be Provided**	**Diagnosis Code [ICD]**	**Service Code(s) Type**	**Code Number**	**Quantity**	**Expected Cost**
Total Expected Charges from [Provider/Facility #1]			$ 0			
Additional Facility/Provider Notes:						

Total Estimated Cost for all Services and Items:(auto populated)	$ 0

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Disclaimers:

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 costs are estimates and not the final overall total charges.

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

Additional items and/or services that are not in the Good Faith Estimate may be recommended by the convening provider as part of the course of care, that must be scheduled separately and are not reflected in the good faith estimate (such as rehabilitation therapies or other post treatment items or services) and information regarding how an you [uninsured (or self-pay) individual] can obtain a good faith estimate for such items or services.

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 askif 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 resolutionprocess, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. The patient-provider dispute resolution process may be started if the actual billed charges are $400 more than the expected charges included in the good faith estimate.

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 the Department of Health & Human Services (HHS) at **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 HHS at **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.