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OMB Control Number 1210-0169

GOOD FAITH ESTIMATE
FOR HEALTH CARE ITEMS & SERVICES

PATIENT INFORMATION

First Name	Middle Name	Last Name
Date of Birth _____ / ____ / _____		
Address		
City	State	Zip Code
Email		

FACILITY/PROVIDER INFORMATION

Facility Name/Type GEORGIA BREAST CARE PC/ BREAST SPECIALIST OFFICE		
Address 900 TOWNE LAKE PKWY SUITE 312		
City WOODSTOCK	State GA	Zip Code 30189
National Provider Identifier (NPI) 1740305408		Taxpayer Identification Number 201756965
Contact Person Billing office – Temeka Jones	Phone 470.308.3699	Email tjones@georgiabreastcare.com

DETAIL OF ITEMS & SERVICES FOR GEORGIA BREAST CARE PC

Item / Service	Address Items/Services To Be Provided	Diagnosis Code	Service Code	Quantity	Expected Charge

TOTAL EXPECTED CHARGES FOR GEORGIA BREAST CARE PC $_____

If scheduled, list the date(s) the items/services will be provided: _____

[ ] Check this box if the items/services have not been scheduled

Date of Good Faith Estimate: _____ / _____ / _____

All charges must be paid on the date of service unless a surgery which must be paid 2 business days prior to the surgery. This charge covers only the professional services. For example, laboratory services, anesthesiology, and surgery center charges will be billed separately from the rendering provider. Upon request, we will provide contact information for these entities so that you can obtain their estimated charges.

DISCLAIMER

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. 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 prices listed 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/consumers or call 1-800-985-3059.

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

Patient Printed Name _____

Patient Signature _____ Date _____

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Email: info@georgiabreastcare.com