HEALTH SERVICES, INC.
Innovative Quality Healthcare.™

# Good Faith Estimate Request Form

Date: _____

Name: _____

Date of Birth: _____

Phone: _____

Email: _____

- What is the date, time, and location of your appointment?

_____

- What is the purpose of the visit? (Please list all of your reasons for a more accurate estimate)

_____

We offer discounted services based on a person's income and the number of people in their household. Your total charges will depend on whether you opted to participate in sliding fee discount program. If you have not chosen to participate in the sliding fee program, then you will pay full price as listed below as Self Pay. When you visit our location, our staff will help you determine your payment group and the sliding fee discount program.

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# 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.

If you are billed more than $400 above the amount on this Good Faith Estimate, 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 404-562-7840.
For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 404-562-7840.