Good Faith Estimate

** indicates a required field*

*** Client's name**

*** Client's date of birth**

* **Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges. I attest that Rachelle Friedman LCSW, NPI number 1689107963, EIN number 101YM0800X, has provided me with a "Good Faith Estimate" regarding my care.**

I consent to sharing information provided here.

* **I understand that this Good Faith Estimate shows the costs of items and services that are reasonably expected for my health care needs for an item or service. The estimate is based on information known at the time the estimate was created.**

I consent to sharing information provided here.

* **I understand that the Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. I could be charged more if complications or special circumstances occur. If this happens, federal law allows me to dispute (appeal) the bill.**

I consent to sharing information provided here.

* **I understand If I am billed for more than this Good Faith Estimate, I have the right to dispute the bill.** _____

I consent to sharing information provided here.

* **I understand that I may contact Rachelle Friedman LCSW, founder of Brainy Social Worker LLC to let them know the billed charges are higher than the Good Faith Estimate.** _____

I consent to sharing information provided here.

* **I understand I 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.** _____

I consent to sharing information provided here.

* **I understand that I may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If I choose to use the dispute resolution process, I must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.** _____

I consent to sharing information provided here.

* **I understand there is a $25 fee to use the dispute process. If the agency reviewing my dispute agrees with me, I will have to pay the price on this Good Faith Estimate. If the agency disagrees with me and agrees with the health care provider or facility, I will have to pay the higher amount.** _____

I consent to sharing information provided here.

* **I understand I may go to the below website to learn more and get a form to start the process www.cms.gov/nosurprises or call HHS at (800) 368-1019.** _____

I consent to sharing information provided here.

* **I understand if I have questions or for more information about my right to a Good Faith Estimate or the dispute process, I may visit www.cms.gov/nosurprises or call (800) 368-1019. I understand I may keep a copy of this Good Faith Estimate in a safe place or take pictures of it in the event I may need it if billed a higher amount.** _____

I consent to sharing information provided here.