

# Good Faith Estimate for Health Care Items and Services



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Service or Item Requested/Scheduled:

- Medication Management

Provisional Diagnosis: **Adjustment disorder, unspecified (F43.20)\***

*\*The Good Faith Estimate requires a diagnosis code. This diagnosis will change after the intake session.*

If scheduled, list the date the Initial Service will be provided: \_\_\_\_\_

Date of Good Faith Estimate: \_\_\_\_\_ Total Estimated Cost: \_\_\_\_\_

The following page is a detailed list of expected charges. The estimated costs are valid until December 31, 2024.

Questions? Contact Kim Woodhouse (405)741-2844

## 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](http://www.cms.gov/nosurprises). For questions or more information about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

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.



# Provider/Facility Estimate

Poyner Mental Health Services  
 14453 SE 29<sup>th</sup>, Suite D Choctaw, Oklahoma 73020  
 405-741-2844 • fax 405-733-1334  
 email [poynermentalhealthservices@protonmail.com](mailto:poynermentalhealthservices@protonmail.com)

National Provider Identifier 1740845361 • Tax Identification Number 83-4694411

Provider Name (National Provider Identifier):

- Chelsea Waldrop, PA-C (1174235832)

## Details of Services and Items for Poyner Mental Health Services

- Medication Management – Estimate valid until December 31, 2024

Service Description	CPT Code	Price	Quantity	Expected Cost
Office or other outpatient visit for the evaluation and management of a new patient which requires a medically appropriate history and/or examination and high medical decision making	99205	\$200	1	\$200
Established patient office or other outpatient visit, low MDM complexity	99213	\$60	24	\$1,440
Established patient office or other outpatient visit, moderate MDM complexity	99214	\$100	12	\$1,200
	99215	\$200	12	\$2,400
Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	90833	\$0	12	\$0
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	99401	\$0	4	\$0
Interactive complexity	90785	\$0	3	\$0
<b>Total</b>				<b>\$5,240</b>

*I have read and understand the Good Faith Estimate for Health Care Items and Services.*

Signature of Patient or Legal Guardian

Printed Patient Name

Date

Office Use Only

Date of Verbal Disclosure:

Date of Email Disclosure:

# Cash or Self-Pay Only

## **You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost**

Under the law, health care providers need to give patients who don't have insurance or who are *not using insurance* an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).