MANHATTAN
PAIN MEDICINE

Good Faith Estimate for Health Care Items and Services

Patient Name:	**DOB:**	
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box:		Apartment
City	State	ZIP Code
Phone:		
Email Address:		
Patient's Contact Preference:	[ ] By mail [ ] By email.	[ ] By phone
Primary Services:	[ ] Pain Management [ ] Rheumatology	[ ] Other

Date of Good Faith Estimate:	
For recurring visits, Valid Until:	End of calendar year
Provider Name: All providers affiliated with Manhattan Pain Medicine	
Estimated Total Cost:	
See attached selfpay fee	

I acknowledge that I have received this information and understand what my out of pocket cost may be.

Signed: _____ Date: _____

MANHATTAN
PAIN MEDICINE

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/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.

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.