**North Market Chiropractic Clinic**

**Shreveport, LA**

**NPI: 1629290713, TIN: 84-3679904**

**Business: 318.222.6601 | Cell: 318.210.8364**

**Good Faith Estimate**

| Patient Name: |  | DOB: |  |
| --- | --- | --- | --- |

| **Estimated Services and Items** | | | **Date of Appointment** | |  | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Description**  **(clear language)**  **Lifestyle Medicine Program (P)** | **Diagnosis Code**  **(ICD-10 Code)** | | **Quantity** | **Expected Cost** | |
| Lifestyle Medicine Program   * Comprehensive Wellness Evaluation (Basic Vision Test, Hearing Test, Pulmonary Function Test, Chest X-Rays, Earwax Removal, Pulse Oximeter) (P) * Urinalysis (R) * Lab Work (CBC, Cardiac Profile, Hemoglobin A1C) (C) * TeleSensi Cardiac Evaluation (Bluetooth cardiac scan of all valves with software print out for primary provider or cardiologist review) (R) * 12 Week Online Lifestyle Medicine Program Consisting of 18 classes (R) | See Attached | | 1 | $2,499 | |
| P - Primary Service (initial reason for visit)  C – Co-provider services  R - Reoccurring Services or item (valid for up to 12 months from date on this form) | | **Total Expected Charges $** | | | | | 2,499 |
| **Date of Good Faith Estimate:** | | | | |  |

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disclaimers:** Comprehensive wellness evaluation including initial assessments and bloodwork are performed to identify abnormalities only. Should medical concerns be present in your test results, a referral will be made to your primary provider or appropriate specialist for further evaluation, treatment and management of your condition as indicated.There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate. The information provided in this good faith estimate is only an estimate of items or services reasonably expected to be furnished at the time this good faith estimate was and actual items, services, or charges may differ from the good faith estimate. You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the good faith estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us 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 within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, 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). This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

LMP