sOcala Natural Medicine PA
D/B/A Natural Medicine Institute
JOHN A. PODLASKI, DC, DACBN, DABCI, DCBCN, CNS, FIAMA
NPI: 1114030400 TIN: 061781730
8564 E. County Road 466, Suite 206
The Villages, FL 32162
352-801-0021

GOOD FAITH ESTIMATE:

DATE:

Patient: **DOB:**

Estimated Services and Items **Appointment Date:**

current Diagnosis is:

DESCRIPTION	SERVICE CODE	EXPECTED COST
( ) LENS Neurofeedback (P)	**Initial Evaluation**	**$ 220.00**
( ) LENS Neurofeedback Treatment (R)	**90901 as needed**	**$ 110.00/visit (up to 30 min)**
		Additional Time: $55/up to 15 min

P - Primary Service (initial reason for visit)
C – Co-provider service
R - Reoccurring Services or item (valid for up to 12 months from date on this form)

Disclaimers: The Diagnosis listed above is only a working diagnosis that may change pending the outcome of the physician's full examination. 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. 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.

I, _____acknowledge that by signing this Good Faith Estimate I have received a copy of this form and my signature does not obligate me to accept any of the recommended consultations, examinations or appropriate Medicare excluded treatment(s) or service(s) and that Medicare or insurance will not be billed by Dr. Podlaski or myself for services related to the wellness care services, examinations or treatments I would elect to receive

_____ _____ _____
Print Name Sign date