Moss Chiropractic Clinic P.C.
David E Moss D.C.
NPI: 1316123102, TIN: 38-2594961
429 North Paw Paw Street, Coloma, MI 49038
269.468.5775

Good Faith Estimate & Disclosure Form

Patient Name:	Date of Birth: ___/___/___

If you do not have health insurance or choose not to bill your health insurance; or, your health benefit plan may or may not provide coverage for all the health care services you are scheduled to receive; or, our practice does not participate with your insurance:

Your health benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network. You may be responsible for the costs of the services that are not covered by your health benefit plan.

A nonparticipating provider must provide good faith estimates of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You also may contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need.

Estimated Services and Items

Date of Appointment	___/___/___

Description (in clear, understandable language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
Spinal Manipulation	MM01.00-M99.08	98940-98942	1	$45-$70
New Patient Visit	MM01.00-M99.08	99202	1	$65
P - Primary Service (initial reason for visit)		**Total Expected Charges $**		$110-$135

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C – Co-provider services R - Reoccurring Services or item **(valid for up to 12 months from date on this form)**		
	Date of Good Faith Estimate:	___/___/___

Disclaimers:

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.

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. Actual items, services, or charges may differ from the good faith estimate. 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.

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, and your bill is $400 or more than your Good Faith Estimate, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You can contact us, let us know the billed charges are higher than the Good Faith Estimate, and 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 (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (approximately four months) of the date on the original bill.

If you dispute your bill, we cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, we are required to cease collection efforts. We must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. We also cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with us, 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

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process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

The initiation of the dispute resolution process will not adversely affect the quality of health care services furnished to you by our practice.

This good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

I have received, read, and understand this disclosure.

_____ _____
Patient or Patient's Representative Signature Date

_____ _____
Type or Print Name of Patient or Patient Representative Date

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