

NEW LIGHT WELLNESS, PLLC
Good Faith Estimate for Health Care Items and Services

Patient Name:			
Date of Birth:			
Address: Street or PO Box			Apartment
City	State	ZIP Code	
Phone:	Email:		
Patient's Contact Preference: ☐ Mail ☐ E-Mail ☐ Phone			

The following is a detailed list of expected charges for your **[LIST PRIMARY ITEM OR SERVICE]** scheduled for **[LIST DATE[S] OF SERVICE, IF SCHEDULED]** as well as for items or services reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care. The estimated costs are valid for 12 months from the date of this Good Faith Estimate.

Provider/Facility Name:		Provider Type:		
Angela Schultz, M.D. NEW LIGHT WELLNESS PLLC				
Provider/Facility Location: Telehealth				
NPI Number:		Tax ID Number:		
Description of Service/Item (Check):	Service Code (Type; Code)	Diagnosis Code (ICD Code)	Quantity/Frequency	Expected Charges
Appointment Type				
☐	Suboxone Treatment			\$ 95.00
☐	Urgent Care			\$ 75.00
☐	Primary Care			\$ 75.00
Testing/Other				
☐				\$
☐				\$
☐				\$
☐				\$
Total Expected Charges:				
Additional Provider Notes:				

Federal No Surprises Act Disclaimer (Uninsured or Self-Pay Patients)

Separate Good Faith Estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the below listed items and services. For items and services included in this list, information such as diagnosis codes, service codes, expected charges, and provider or facility identifiers will be provided in separate Good Faith Estimates upon scheduling or upon request of such items or services. A good faith estimate may be obtained by contacting NEW LIGHT WELLNESS at (947) 281-9111 or info@thenewlightwellness

Items and Services Requiring Separate Scheduling:
1. Suboxone Treatment
2. Urgent care
3. Primary care

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.

There may be additional items or services the convening provider recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the Good Faith Estimate.

The Good Faith Estimate is not a contract and does not require you to obtain the items and services from any of the providers or facilities identified in the Good Faith Estimate.

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 for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to you by a provider or facility.

If you are billed for more than this Good Faith Estimate, you may 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.

If you dispute your bill, the provider or facility 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, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility 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 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 <https://www.cms.gov/medical-bill-rights> 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, email FederalPPDRQuestions@cms.hhs.gov, 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.