COUNSELING ASSOCIATES
OF CENTRAL IOWA, PC

Good Faith Estimate for Health Care Items and Services

Date:			**CACI NPI: 1073752218**
Patient Full Name:			Date of Birth: / /
Street Address:			
City:			State: Zip Code:
Phone:			
Primary Diagnosis (if applicable):_____ Diagnosis Code:			
Secondary Diagnosis (if applicable):_____ Diagnosis Code:			
Date(s) of Service	Description	Service Code	Estimated Amount to be Billed
Total Estimate of What You May Owe:			
Provider Signature:		Date:	

The estimated costs are valid for 12 months from the date at the top of this Good Faith Estimate. If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan.

Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for the above noted service. The estimate is based on information known on the date 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 you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

I acknowledge that I have read the above information, have had an opportunity to ask questions, and I agree to engage in the service(s) listed above.

_____ Date: _____

Patient or Guardian's Signature