Deep Roots Family Medicine

Good Faith Estimate Notice and Consent

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate (GFE) of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage at the time of scheduling health care items and services.

We hope the following will help you understand the investment you may need to make in your well-being. At Deep Roots we treat you as an individual, so please communicate with your provider if you are self-pay so they can ensure you are educated about treatment plan costs including diagnostic tests. Also, communicate with your health insurance company about your specific plan if you decide to bill insurance.

► **Review the rates.** Below are our most common rates by appointment type or service. You can always request a specific estimate for any of our services.

► **Call your health plan if you have one.** Your plan will have better information about how much you will be asked to pay if a service is billed to insurance and not covered or out-of-network. In some cases, you may end up paying more than our self-pay rate because of deductible and insurance industry requirements.

This GFE gives you an estimate of potential costs. *Total cost may change depending on length of visit, complexity of visit, additional services provided, and products given at time of service.* Deep Roots Family Medicine offers a 30% discount for some office visits if patients pay at time of service and do not bill an insurance company. By signing you agree that you have read and understood the GFE and agree to the costs associated with receiving services at our clinic.

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I may get a bill for the full charges for these items and services,
- If I choose to bill insurance, I may have to pay out-of-network or non-discounted rates.
- I understand that some or all amounts I pay Deep Roots may not count toward my health plan's deductible or out-of-pocket limit.
- I can stop services at any time and will owe for services provided.
- I can request a specific estimate for any service at any time.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, we reserve the right to not treat you and can refer you to another provider.

Patients Name_____

_____ Date:_____ Or _____ Date:

Patient's Signature **Guardian/authorized representative's signature**

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Rates and Self-Pay Discount (when payment is made at time of service)

The amount below is only an estimate; it isn't an offer or contract for services. This means that **the final cost of services may be different than this estimate**. The ranges below are representative of variations in length of visit, complexity of visit, additional services provided, and supplies needed at time of service.

Services	Rate	With 30% Self Pay Discount (applied when payment is made at time of service)
New Patient Visits	$225-500	$160-350
Office Visits (Follow-up)	$150-400	$105-280
Well Exam	$200-250	$160-175
Pediatric Well Exam	$225	$160
Telehealth	$120-400	$84-280
Extended Visits	$100	$70
Mind Body Therapy	$175	NA
After Hour Phone Calls	$40 to $150	NA
Constitutional Hydrotherapy	$150	NA
Constitutional Hydrotherapy Package of 5	$600	NA
LENS/Reiki	$125	NA
LENS/Reiki Package of 5	$500	NA
New Patient Acupuncture Visit	$150	NA
Acupuncture Followup	$100-250	NA
Nutritional Counseling	$130	NA
Testing	$50 - $450	NA
Blood Draw	$25	NA
Lab Handling	$15	NA