David F. Young MD, PC
DERMATOLOGY

David F. Young MD, PC
Esther Carson, PA-C
Christa Cavanaugh, PA-C

GOOD FAITH ESTIMATE FOR HEALTH CARE ITEMS AND SERVICES

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Preferred Contact Preference: ☐ Mail ☐ Email

Patient Email: _____ Reason for Visit: _____

Disclaimer: Below is the Good Faith Estimate that shows the costs of services/items that are expected based on the information known at the time the estimate was created. Unknown or expected costs may arise during treatment. If this happens, and you are billed more than this Good Faith Estimate, you have the right to dispute the bill.

Provider Name _____ Practice Name _____

Provider NPI _____ Provider Tax Identification Number _____

Details of Services/Items

Services/Items	Diagnosis Code *(only required if cost dependent)*	Service Cost	Expected Cost
		Total Expected Charges:	

Additional Health Care Provider Notes:
(Additional Services needed to be separately scheduled and not included in the GFE)

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit **www.cms.gov/nosurprises/consumers** or call **1 (800) 985-3059**.