



## **Good Faith Estimate 2026**

**The purpose of this document is to inform you about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care if your insurance isn't contracted with our clinic or if you choose to have a service that is not covered by your insurance**

**Getting care from this provider or facility could cost you more if your insurance is out of network.**

### **No Surprise Billing Info**

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

### **Estimate Of What You Could Pay:**

- ▶ Review the listed estimates below
- ▶ Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ Questions about this notice and estimate? Call our office @ 509-881-0722

### **Prior authorization or other care management limitations**

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage. You will likely need a visit with an in-network doctor.

### **Good Faith Estimate for LIM**



The amount below is only an estimate; it isn't an offer or contract for services. This is only an estimate regarding the items or services expected to be furnished and actual items, services, or charges may differ. It doesn't include any information about what your health plan may cover. This means that the final cost of services may be different than this estimate. There may be additional items or services the provider recommends as part of the course of care that must be scheduled or requested separately and are not included in the original GFE.

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

**Costs of Visits (this is a basic and not a complete list of all office services and procedures):**

**New Patient (60min): \$290**

**Follow up (30 min): \$175**

**Preventative Wellness New Patient: \$225**

**Preventative Wellness Established Patient: \$175**

**Telemed: \$75-\$125 (depends on length of time)**

**Acute: \$75-125 for established patients only (depends on length of time and complexity)**

**Lab draw: \$25 (does not include the price of labs) Please call/email for specific lab prices**

**PRP: \$250 (for one location, increases with additional locations)**

**BHRT Pellets: \$250-\$450 (price depends on # of pellets)**

**Childhood vaccine: \$23/each**

**OMT/Adjustments: \$50-\$100**



Visits are expected to be more frequent in the beginning of treatment. Depending on the service provided visit frequency may range from weekly to possibly every 2-3 weeks or even monthly. Once stable, patients may require visits less frequently, as infrequent as once every 12 months for medication management patients.

**We do charge \$25-50 for missed appointments OR appointments that are canceled later than 24 BUSINESS HOURS of the appointment time. Dr. Bridges NCS monthly and yearly patients have waived missed appt fees.**

### **Disclaimer**

►Questions about your rights? Call this federal phone number for information and complaints: 1-800-985-3059.

You may also visit: [www.cms.gov./nosurprises](http://www.cms.gov./nosurprises)

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.

### **Signature**

**By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.**

***IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility will not treat you. You can choose to get care from a provider or facility in your health plan's network IF your insurance is out of network.***

**Patient OR Guardian/Authorized**

**Representative's Signature: \***

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**DATE: \***

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