NorCal Integrity Surgery

Good-Faith Estimate of Expected Charges

(Provided in accordance with the federal No Surprises Act)

Patient: _____ DOB: _____ Date issued: _____

Scheduled procedure(s): _____ Anticipated date of service: _____

Provider: Colin Dunn, MD — NorCal Integrity Surgery, Los Gatos, CA

Estimated Charges

CPT	Description	Billed charge	Est. insurance payment	Est. patient responsibility

Estimated total patient responsibility: $_____

This estimate is based on benefits verified with your insurer on _____ and on your plan's deductible, coinsurance, and out-of-pocket status as of that date. This is an estimate only and not a guarantee. Your actual responsibility is determined after your insurer processes the claim (the Explanation of Benefits). Additional services identified during surgery may change the total.

You have the right to a good-faith estimate. If your final bill is at least $400 more than this estimate, you may be able to dispute it through the federal patient-provider dispute resolution process (details at cms.gov/nosurprises).

Patient Acknowledgment

I received and reviewed this good-faith estimate.

Signature: _____ Date: _____