Good Faith Estimate Form and Consent

Patient Name:_____

Date of Birth: _____

Out-of-network provider: Anjum S. Khan, MD at NorthStar Rehab + Pain Clinics, PLLC

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. 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**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Date of Service	Service Code	Description	Estimated Amount to be Billed

Total Estimate of what you may owe: _____

I acknowledge that NorthStar Rehab + Pain Clinics, PLLC provided me with a Good Faith Estimate prior to services rendered.

Patient/Guardian Signature:_____ Date: _____

If Guardian signing for Patient, relationship to patient: _____