Good Faith Estimate (GFE)

For Uninsured or Self-Pay Patients

Patient Name: ____ **Date of Birth**: __________________

Diagnosis Code(s): ____ **Date of Service**: __________________

This estimate is provided under the terms of the No Surprises Act of 2021. The practice of medicine is unpredictable, and as a result, this document provides only an estimate of charges for your visit and not the final patient responsibility; actual items, services, or charges may differ. There may be additional items or services the convening provider recommends as part of the course of care that must be scheduled or requested separately and are not included in the GFE.

Office Visits

New Patients	CPT Code	Price	Existing Patients	CPT Code	Price
Level 2 Visit	99202	$99	Level 2 Visit	99212	$74
Level 3 Visit	99203	$149	Level 3 Visit	99213	$104
Level 4 Visit	99204	$189	Level 4 Visit	99214	$144
Level 5 Visit	99205	$249	Level 5 Visit	99215	$184
Comprehensive Exam	92004	$169	Comprehensive Exam	92014	$144

Complexity of office visits (determination of level) depends on a number of factors and is determined by the physician/physician assistant. Most commonly, ophthalmic office visits are level 3 or 4.

Procedures

Description	CPT Code	Price
Refraction	92015	$35
Optomap	S9986	$39
Anterior Segment OCT	92132	$135
ONH OCT	92133	$135
Retina OCT	92134	$135
OCT Screener	SOCT	$15
iLux Dry Eye Treatment	iLux	$599
Visual Field	92083	$150
Foreign Body Removal (Conjunctival)	65205	$115
Foreign Body Removal (Corneal)	65222	$115
Closure of Lacrimal Punctum by Plug (per eye)	68761	$250
Dilation of Lacrimal Punctum (per eye)	68801	$149
Other: ____	_________	$____

I have been provided a copy of the good faith estimate of charges and acknowledge that I will be responsible for payment of the above services. The individual has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess (over $400) of the expected charges included in the GFE. This good faith estimate is not a contract and does not require the uninsurance (or self-pay) individual to obtain the items and services from any of the providers or facilities identified on the good faith estimate.

Estimated Cost: ____

Patient Signature: ____ Date: ______________

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