Good Faith Estimate

Thank you for choosing The South Bend Clinic as your health care provider. We are committed to providing patients with quality and affordable health care. Below is the “good faith estimate” for the nonemergency medical services that you inquired about.

This estimate is not binding on the practitioner; the price the practitioner charges may vary from the estimate based on your individual medical needs; the estimate provided below is only valid for 30 days.

Send Requests to costestimate@southbendclinic.com

Date of inquiry: ______________________ MR: ______________________

Patient Name: __________________________________ DOB: ____________

Patient email: ____

Insurance: ____

Self-Pay: ____

Referring Provider (if applicable): ______________________________________

Description of Services: ____

Facility (ASC) Estimated Charges $ ____________________________________

Description of Services: ____

Professional (Doctor) Estimated Charges $ _______________________________

Discount: ____

Total Estimated Charges $ ____

Estimate given by: Date: 8/27/2020