Surprise Billing Protection Form

The purpose of this document is to let you know 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.

IMPORTANT: You are **NOT** require to sign this form and should **NOT** sign if you did not have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.
If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or **keep a copy of this form for your records.**

You are receiving this notice because this provider or facility is **NOT** in your health plan's network. This means the provider or facility does **NOT** have an agreement with your plan.

GETTING CARE FROM THIS PROVIDER OR FACILITY COULD COST YOU MORE

If your plan covers the item(s) or service(s) you are getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

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.

You should **NOT** sign this form if you did **NOT** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Estimate of What You Could Pay if you give up your protections

Patient Name: ____

Out-of-Network provider(s) or facility name: ______________________________________

____

Total cost estimate of what you may be asked to pay:	$________________________________

▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

▶ **Call your health plan.** Your plan may have better information about how much you'll 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?** Contact 651-645-3115 to speak to someone at our office.

▶ **Questions about your rights?** Contact 1-800-985-3059 or visit www.cms.gov/nosurprises

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 the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding Your Options

You can get the items or services described in this notice from the following providers who are in-network with your health plan.

More Information about Your Rights and Protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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

With my signature, I am saying that I agree to get the item(s) or service(s) from (select all that apply):

☐ Psych Recovery Inc. (Providers included)

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I am giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on **DATE** explaining that my provider or facility is **NOT** in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I have received the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You do **NOT** have to sign this form. But if you do **NOT** sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

________________________________	or	________________________________
Patient Signature		Guardian/Authorized Rep Signature
________________________________		________________________________
Print Patient Name		Print Guardian/Authorized Rep Name
________________________________		________________________________
Date & Time of Signature		Date & Time of Signature

Take a photo and/or keep a copy of this form.

It contains important information about your rights and protections.

More Details about Your Total Cost Estimate

Patient Name: ____

Out-of-Network provider(s) or facility name: ______________________________________

____

The amount below is only an estimate; it is **NOT** an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does **NOT** 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 if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

Date of Service	Name of Provider or Facility	Service Code	Description	Estimated Amount to be Billed
Subtotal for (insert provider or facility):				**$**______________
Total Estimate of What You May Owe:				**$**______________