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.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're 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 outof-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.

Out-of-network provider: **Hurt and Healing Behavioral Health and Wellness**

►**Review your** detailed estimate attached for a cost estimate for each service you'll get.

►**Call your health plan**. Your plan may have better information about how much you will 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?** Call us at 252-652-6047

►**Questions about your rights?** Contact 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 services. This means you may need your plan's approval that it will cover a service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage. You will be responsible for any services not covered by your plan, including **LATE CANCELLATION AND NO-SHOW FEES.**

Understanding your options: You can also get the services described in this notice from providers who are in-network with your health plan.

For more information about your rights and protections: Visit https://www.cms.gov/nosurprises 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 items or services from: Hurt and Healing Behavioral Health and Wellness.

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'm giving up some consumer billing protections under federal law.**
- **I may get a bill for the full charges for these services or have to pay out-of-network cost-sharing under my health plan.**
- **I was given a written notice on TODAY explaining that my provider or facility isn't 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 got 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 don't 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.

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

It contains important information about your rights and protections

<u>Estimate of What You Could Pay:</u> 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 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.

ONLY THE SERVICES MARKED PERTAIN TO YOU:

X	Dates of Service	Service Code	Description	Estimated amount to be billed	Initial
	Weekly or Biweekly	90837	Psychotherapy w/ Psychologist	$200	
	Annually	90791	Diagnostic Assessment	$200	
	Weekly or Biweekly	90834	Psychotherapy w/ Therapist	$125	
	Weekly or Biweekly	90847	Family/Couples Psychotherapy	$200	
	1st Appt		Initial Appointment	$200	
	Weekly or Biweekly		Telehealth	$125-$200	
	Total Estimate of what you may owe:				

_______________________________________ _______________________

Patient/Guardian/authorized representative's signature **Date**

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Print name of patient/guardian/authorized representative