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 aren't required to sign this form and shouldn't sign it if you didn't 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're getting this notice because this facility isn't in your health plan's network. This means the facility doesn't have an agreement with your plan.

Getting care from this facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When an out-of-network provider treats you at an 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 **shouldn't** sign this form if you **didn't** 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

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 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 [*Enter contact information for a representative of the facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

► **Questions about your rights?** Contact HHS No Surprises Help Desk at **1-800-985- 3059**

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 an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

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 (select all that apply):

☐ Ocean Renal Associates, P.A.

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 items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my 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 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 facility in writing before getting services.

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

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

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

It contains important information about your rights and protections.

More details about your estimate

Patient name: _____

Out-of-network facility name: _____

_____

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.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	