**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.

You’re getting this notice because this provider or facility isn’t in your health plan’s network OR bills for services which are NOT covered by your health plan. This means the provider or facility doesn’t have an agreement with your plan OR you plan will not cover investigation or experimental treatments.

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 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.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility OR you can refuse services deemed as experimental or investigational.

It is within your right to get a total cost estimate of what you may be asked to pay:

►Review your detailed estimate.

►Call your health plan

►Questions about this notice and estimate?

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

* [Doctors and Staff at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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 must pay out-of-network cost-sharing under my health plan.

• 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 don’t 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.

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Patient’s signature Guardian/authorized representative’s signature

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Print name of patient Print name of guardian/authorized representative

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Date of signature Date and time of signature