Surprise Billing Protection Form

As of January 1, 2022, Birthstone Trauma Healing is providing a "good faith estimate" for all services provided. The purpose of this document is to let you know about your protections from unexpected medical bills. At all times, it is a prerequisite of care that you know and accept the cost of services rendered. As an insurance policyholder, you have specific rights and protections when you receive in-network care, but these rights do not apply when you receive out-of-network services. In lieu of your choice to waive these protections, we are transparent about the estimated costs of your services at Birthstone. This form lays out your rights, and allows you to endorse whether or not you would like to forego those in-network 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 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 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.

What You Could Pay

Patient name:

Out-of-network provider(s) or facility name: Birthstone Trauma Healing, LLC

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 your insurance company's service phone number on the back of your card.

►**Questions about your rights?** Contact the No Surprises Help Desk at 1-800-985-3059.
Prior authorization or other care management limitations

Bottom Line

Birthstone Trauma Healing is an out-of-network provider. All services must be paid out-of-pocket at or before the date and time of service. You may be eligible for post-service reimbursement by your insurance company depending on your personal out-of-network benefits. At your request, Birthstone provides a receipt called a superbill, which is designed for your insurance company to use as an out-of-network claim. The best step for clarity on what you may owe after claim-submission is to call your insurance company after receiving your estimate from Birthstone.

***It is up to you as the client to coordinate with your insurance company. Birthstone does not provide clinical information without consent from your to share medical information with your insurance company.**

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.]

Understanding Your Options

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

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 Birthstone Trauma Healing.

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 was given a written notice on [*enter date of notice*] 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 **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.

BIRTHSTONE
TRAUMA HEALING

Signature Page

Patient Name	Patient's signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian signature	Date
_____	_____	_____

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.

Estimate of Services

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.
Thismeansthat**thefinalcostofservicesmaybedifferentthanthisestimate**.

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 provider or 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.*].

Total estimate of what you may owe:

Date of Service	Service Code	Description	Estimate to Be Billed

BIRTHSTONE
TRAUMA HEALING

Good Faith Estimate for Health Care Items and Services

Patient First, Middle, Last:

Patient Date of Birth:

Patient Mailing Address:
Street or PO Box:
City, State, Zip:

Patient Phone:

Patient Email Address:

Contact Preferences:

Patient Primary Diagnosis and Code:

Patient Secondary Diagnosis and Code:

List Date(s) of Services Scheduled:
Frequency of Sessions Estimated:
Number of Sessions Estimated:
List Date(s) of Services Scheduled:
Date of Good Faith Estimate:
Provider Name: Timothy Sosin, MA, LPC, NCC
Total Estimated Cost:

"The estimated costs are valid for 12 months from the date of the Good Faith Estimate."