Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

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

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

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: Pro Therapy Center, PLLC

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 Grace Johnson 734-331-0040

►**Questions about your rights?** Contact 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 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 understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from

☐ Pro Therapy Center, PLLC

With my signature, I acknowledge that I'm consenting of my own free will and I'm not

being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services or have to pay additional out of network cost-sharing under my health plan.

- I was given a written notice on that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed 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 of the 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. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____

Patient, Guardian, authorized representative's signature

_____

Print name of patient, guardian, authorized representative

_____

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 total cost estimate

Patient name: _____

Out-of-network provider(s)or facility name: Pro Therapy Center, PLLC

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 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
	Pro Therapy Center, PLLC	90791	Therapy Intake / Psychiatric Diagnostic Evaluation	$180.00/session
	Pro Therapy Center, PLLC	90837	53+ minutes psychotherapy	$170.00/session
	Pro Therapy Center, PLLC	90834	38-52 minutes psychotherapy	$150.00/session
Subtotal for Pro Therapy Center, PLLC:				$
Total estimate of what you may owe:				