NORTHEASTERN CENTER
YOUR COMMUNITY COUNSELING CENTER

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 provider or facility might not be 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.
- When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out of network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount.
- Questions about your rights? The federal phone number for information and complaints is 1-800-985-3059.
- 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.

For more information about your rights, visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Client Initials: _____

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Estimate of Charges:

Please see the following price transparency table which shows the maximum cost that you may be charged for a nonemergency medical service provided by a health care facility or provider to see estimate of charges you could receive. Indiana law requires that an estimate be provided within 5 business days of the request for an estimate for scheduled, ordered, or referred a nonemergency health care service. In addition, if you are uninsured or intending to pay for the service out of pocket, federal law request that a provide or facility provide you with an estimate for all scheduled nonemergency health care services at least 1 business day before the services are performed.

You're never required to give up your protections from balance billing. You also aren't requested to get care out of network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provide or facility was in-network). Your health plan will pay out of network providers and facilities directly.
- Your health plan generally must:
  - Cover your emergency services without requiring you to get approval for services in advance (prior authorization)
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and who that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services towards your deductible and out of pocket limit.

Client Initials: _____

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Authorized Signature Form

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 the Northeastern Center.

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 _____ 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.

_____ or _____

Client's signature | Guardian/authorized representative's signature

_____ _____

Print name of client representative | Print name of guardian/authorized

_____ _____

Date and time of signature | Date and time of signature

You may request a copy of this form

FOR OFFICE USE ONLY: ☐ Client refused to sign per _____ (*Staff Initials*) ☐ Client unable to sign per _____ (*Staff Initials*)