

Matt F. Butryn, Ph.D., LLC

Clinical Neuropsychologist

Pediatric, Adult, and Forensic Psychology

"No Surprises" Act Disclosure

Good Faith Estimates

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

The Good Faith Estimate is not a contract and does not require you to obtain services from the listed provider. You are free to discontinue services at any time.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.



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Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit

www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1- 800-985-3059.

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: _____

Total cost estimate of what you may be asked to pay:	
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- ▶ **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 [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]
- ▶ **Questions about your rights?** Contact [Insert contact information for appropriate federal or state agency. The federal phone number for information and complaints is: 1-800-985-3059]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

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.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

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 [Insert website describing federal protections, such as 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 (select all that apply):

- [doctor’s or provider’s name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*
- [facility name]*

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 *[enter date of notice]* 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’s signature	or	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 total cost estimate

Patient name: _____

Out-of-network provider(s) or 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 if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

[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.]

For each provider or facility described in the notice, fill-in the table below by completing each column for each item and service to be provided by the provider or facility. Add additional rows if necessary. If the notice is for more than one facility or provider, list items and services to be provided by the same facility or provider in adjacent rows, and provide a subtotal estimate for each facility and provider(s). If the notice is for one facility or one provider, the subtotal estimate may be omitted. 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	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
Subtotal for [insert name of provider or facility]:				
Total estimate of what you may owe:				