SURPRISE BILLING PROTECTION FORM

Patient name:_____ Account #:_____

Date of Service:_____

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 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.

A copy of this form for your records may be provided upon request.

You're getting this notice because this facility isn't in your health plan's network and is considered out-of-network. This means the facility doesn't have an agreement with your insurance plan to provide services.

Getting care from this provider or facility will likely cost you more.

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

- When you're getting emergency care from an out-of-network hospital or facility, or
- When 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 are giving up 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 facility, or another one.

Please refer to the cost estimate provided to you via email or text. If you did not receive a copy of the cost estimate or have questions, please call the billing department at (574) 544-2200.

Out-of-network provider(s) or facility name: Allied Physicians Surgery Center

- **Review your detailed estimate**. See the cost estimate for each item or service you'll get provided to you via email and/or text message.

- **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 Patient Accounts Department at (574) 544-2200.

- **Questions about your rights?** Contact CMS (for federal rights) at 1-800-985-3059. Or, for your rights specific to Indiana, contact The Indiana Department of Insurance at 317-232-2395.

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.

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:

- Allied Physicians Surgery Center

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 notice, either on paper or electronically, that explained my 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 facility.
- 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 facility might not treat you, but you can choose to get care from a facility that's in your health plan's network.

_____	Or	_____
Patient's signature		Guardian/authorized representative's signature
_____	Or	_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature