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 providers 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. 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:

Ask your health care provider 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 provider 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.

See the next page for your cost estimate.

Andrews & Associates
Good Faith Estimate of What You Could Pay

Client: _____DOB: _____ Today's Date: _____

Out-of-network provider(s)or facility name: _____

In accordance with the law, Andrews and Associates Counseling is providing a Good Faith Estimate. The Good Faith Estimate explains how much your mental health treatment will cost if you do not have insurance or are not using insurance.

The Good Faith Estimate is for the total expected cost of any non-emergency healthcare services, including psychotherapy services. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

- **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?** Contact your provider for any questions.
- **Questions about your rights?** Contact https://www.cms.gov/nosurprises
- **Prior authorization or other care management limitations:** Except in an emergency, your health plan may require prior authorization for certain items and services. If prior authorization is required, ask your health plan. ***Mental health services typically do not apply.***
- **Understanding your options:** You can also receive the items or services described in this notice from providers who are in-network with your health plan. Please contact your health plan for a list of providers.
- **More information about your rights and protections:** Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Statement of Understandings

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I understand that I am giving up some consumer billing protections under federal law and I am responsible for the charges listed on the estimate for these items/services. I acknowledge that: I was given: 1.) A written notice or received electronic notice explaining that my provider or facility is not in my health plan's network; 2.) The estimated cost of services and what I may owe if I agree to be treated by this provider or facility. I understand I can terminate this agreement by notifying the provider or facility in writing before obtaining services.

I **agree to receive services from (select all that apply):**

☐ Andrews & Associates Counseling ☐ _____(Provider)

Total cost of what you may be expected to pay: $_____

_____ _____

Patient/Guardian/Representative Signature Date

Details About Your Estimate

Patient name: _____ Today's Date: _____

Out-of-network provider(s) or facility name: _____

NPI#: _____ Tax ID# _____

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not 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 how much, if any, your plan will pay and your cost.

DX	SERVICE	NUMBER OF SESSIONS	COST
		TOTAL:	

Office Location:

- 1506 Browning Place, Manhattan
- 1201 Poyntz Ave, Manhattan
- 2029 Vanesta Place, Manhattan
- 929 S Washington, Junction City
- 406 Lincoln, Wamego