

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 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 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 could cost you more.**

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

- You're get emergency care from out-of-network providers and facilities, or
- An out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent to receive a higher bill.

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're giving up your legal protections from higher bills.
- You may owe the full costs billed for 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 Veterans Memorial Hospital and Clinics Financial Services 563-568-3411.
- ▶ **Questions about your rights?** Visit <https://www.cms.gov/nosurprises> or 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 an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

Dr. Schwartz, MD

More information about your rights and protections

Visit <https://www.cms.gov/nosurprises> 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 am 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]

Veterans Memorial Hospital and Clinics, Waukon, IA

With my signature, I acknowledge that I am consenting of my own free will and I'm not being coerced or pressured. I also understand 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. But 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 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 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:				