Boston Children's Health Physicians
New York & Connecticut

Surprise Billing Protection Form – Non-Emergency Care

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 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:

- 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 written 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. See the next page for your cost estimate.

Estimate of what you could pay

Patient name:

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

Total cost estimate of what you may be asked to pay:	**$188.50, $190.00, $127.50, OR $148.00 PER SESSION**

► **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 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 the person who gave you this form or call: Kim Palmer or Kayla Aguirre Guerrero, 845-614-8481 or 845-496-1025

► **Questions about your rights?**

New York State - https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills
(800) 342-3736

Connecticut – https://portal.ct.gov/OHA/ODCO/About-Us/About-OHA
(866) 466-4446

Federal - https://www.cms.gov/nosurprises/consumers

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 other providers who are in-network with your health plan. Contact your health plan who can assist you with finding in-network providers.

More information about your rights and protections

https://www.cms.gov/nosurprises/consumers

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 (select all that apply):

☐ Providers employed by Boston Children's Health Physicians

Provider names: _____

_____

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 understand that consent for the out-of-network services is optional, and I can instead opt for an in-network provider.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given notice that the above provider is not in my health care plan's network at least 72 hours in advance of the services to be provided and have been given a meaningful opportunity to choose an in-network provider in advance of receiving these services. I have received an estimated cost of services and what I may owe by agreeing to be treated by this provider.
- 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 _____

Patient's signature | 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 how much, if any, your plan will pay and how much you may have to pay.

Date of Service	Service Code (CPT)	Description	Estimated amount to be billed
TBD	90791	Psych Diagnostic Eval	$188.50
TBD	90837	Psychotherapy (60 Mins)	$190.00
TBD	90834	Psychotherapy (45 Mins)	$127.50
TBD	90846	Family Psychotherapy Without Patient (30 Mins)	$148.00
		Total estimate of what you may owe:	**$TBD BASED ON ABOVE**

Above amount must match with total cost estimate on page 2

Attention BCHP Staff

Please contact Denise_Shivnarain@bchphysicians.org or Melissa_Morrell@bchphysicians.org to obtain the rates for each CPT code / service to be provided.