

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 healthcare 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 Physical Therapy for Women isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan or patient chooses to continue care without utilization of their insurance plan.

Getting care from Physical Therapy for Women 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 consent.

Ask your healthcare 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.

Good Faith Estimate for Health Care Items and Services for

Patient Name:		Date of Birth			
Fatient NameFirst Name	Middle Name		Last Name		
Street or PO Box		City	State	Zip code	
			Patient's Contact Preference	e: [] By mail	
Telephone number	Email address			[] By email	
C	ost estimate of what	t you may b	e asked to pay:		
\$125.00 - Initial Evaluation.					
\$100.00 - Each additional vis	it during the recomme	ended Plan o	f Care outlined by your Therap	ist.	
Any supplies, garments or w	rapping material need	ed during tr	eatment will be discussed prior	r to applying	
This means you may need your pis required, ask your health plan	Visit www.cms.gov/nosur e management limitations alth plan may require prior plan's approval that it will o	authorization	(or other limitations) for certain item or service before you get them. If pric		
Understanding your options You can also get the items or se will need to contact your health		-	viders who are in-network with your h	ealth plan: You	
By signing, I give up With m	my federal consumer pro y signature, I am saying th	otections and a nat I agree to g	agree to pay more for out-of-networl get the items or services from 16539 Tax Id: 562322824):	k care.	
•	edge that I am consenting		re will and am not being coerced or p	oressured. I also	
• I'm giving up some consumer b	oilling protections under fe	deral law.			
plan.			to pay out-of-network cost-sharing เ	·	
estimated cost of services, and	what I may owe if I agree	to be treated b		plan's network, th	
 I got the notice either on paper 	or electronically, consister	nt with my cho	ice.		

- 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.

	, , , , , , , , , , , , , , , , , , ,			
Print Patient/Guardian/authorized representative name	Signature of Patient/Guardian /authorized representative	 Date		