No Surprise Billing Waiver/Consent

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

Our providers are contracted with many insurance plans. We will file your insurance in accordance with our agreement with the plan as a ***courtesy to our patients***. We will try to inform you if the provider is out of network, however it is ultimately your responsibility to understand your insurance policy and benefits and contact your insurance carrier if you have any questions regarding providers that you see.

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 will likely cost you more.**
- You are uninsured.
- You are a self-pay patient.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the 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.

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Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

With my signature, I'm agreeing to get items or services from ***Capstone Clinics***.

With my signature, I acknowledge that I'm consenting at my own free will 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 that explained my provider or facility isn't in my health plan's network, a good faith estimate, 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. If you don't sign, this provider or facility will not treat you. You can choose to get care from a provider or facility that's in your health plan's network.

Patient's signature Guardian/authorized representative's signature

Date

Print name of patient Print name of guardian/authorized representative

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.