# ATLANTIC EYE CENTER
# 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 are not required to sign this form and should not sign it if you did not 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 would 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.**

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You are getting this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not 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 are 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 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 **should not** sign this form if you **did not** 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 is not 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 Out of Network

Patient Name: _____

Out-of-network providers: Dr. Kostick & Dr. Cordero, Atlantic Eye Center Providers

**Total cost estimate of what you may be asked to pay: _____**

- **Review your detailed estimate**. Please see attached cost estimate for each item or service you will receive.
- **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 is covered under your plan and your provider options.
- **Questions about this notice and estimate**? Please call the office at 386-446-9590 to speak to a patient services representative for an explanation of the document or estimate or to answer any questions you may have.
- **Questions about your rights**? Visit www.cms.gov.nosurprises.

**Prior Authorization or Other Care Management Limitations**
Any prior authorization or plan coverage information that individual needs to know:
_____

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 the providers who are in network with your health plan.

**More Information About Your Rights and Protections**
Visit www.cms.gov.nosurprises for more information about your rights under federal law or call 1-800-985-3059.

# Agreement to Pay More for Out of Network

**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:

- Dr. Kostick & Dr. Cordero
- Atlantic Eye Center

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 am giving up some consumer billing protections under federal law.
- 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 a written notice on _____ explaining that my provider or facility **is not** in my health plan's network, the estimated cost of services, and 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 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 **do not** have to sign this form. But if you do not 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 | Authorized representative's signature

_____ _____

Print name of patient | Print name of 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.**