

## 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 before scheduling 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.

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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.**

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

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

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.

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: \_\_\_\_\_

<b>Total cost estimate of what you may be asked to pay:</b>	
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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 Joel Kouyoumjian to explain the documents and estimates and answer any questions, as necessary.
- ▶ **Questions about your rights?** Contact the federal No Surprises Help Desk for information and complaints at 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 the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

#### Understanding your options

You may be able to receive similar services described in this notice from other provider types who are in-network with your health plan: Osteopathic Physician, Psychiatrist, Kinesiologist, Chiropractor, Acupuncturist, Physical Therapist, or Occupational Therapist. To our knowledge, none of these provider types within our service area are certified in Myoskeletal Alignment Techniques.

#### More information about your rights and protections

Visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) 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'm agreeing to get the items or services from (select all that apply):

- Joel Kouyoumjian, LMT MMT
- Manchester Bedford Myoskeletal LLC

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



conjunction with such items or services booked by the patient. This table is based on the single scheduled visit to this provider described whether ALL coverage would be denied by your insurer or not.

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
	Joel Kouyoumjian			
<b>Subtotal for Joel Kouyoumjian:</b>				
<b>Total estimate of what you may owe:</b>				