4675 HILL STREET
CASS CITY, MI 48726

Hills & Dales HEALTHCARE

(989) 872-2121
WWW.HDHLTH.ORG

Surprise Billing Protection Form

The purpose of this document is to let you know about your protection 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 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.

Ask your provider or a patient advocate if you want assistance with this document. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility is not 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 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 amounts 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 signing this form, 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.

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 to cover an item or service before you get it. If prior authorization is required, ask your health plan for the necessary information to get coverage.

Understanding your options

Patient Label or
Patient Name
DOB
MR#
Date

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You can also get the items or services described in this notice from these 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.

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):

☐ (enter in doctor's name) _____

☐Hills and Dales General Hospital

With my signature, I acknowledge that I consent to 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 may get a bill for the full charges for these items and services or pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't 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 **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.

_____	_____
Patient Signature	Guardian/Authorized Representative Signature
_____	_____
Printed Name of Patient	Printed Name of Guardian/Authorized Representative
_____	_____
Date/Time of Signature	Date/Time of Signature

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.

Patient Label or
Patient Name
DOB
MR#
Date