Singer Dermatology

Surprise Billing Protection Form Waiver

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'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 this provider or facility is not in your health plan's network, or you agree to be seen without a proper referral from your HMO plan. This means the provider or facility does not have an agreement with your plan, or you are being seen without a proper referral.

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 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

Patient

name:_____

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

►**Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you will get. ►**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's covered under your plan and your provider options.

►**Questions about this notice and estimate?** Call our office manager (Ms. Little at 248-228-2990 or email her at officemanager@singerskin.com

►**Questions about your rights?** Contact your health plan and/or visit

https://www.cms.gov/nosurprises

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 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 these providers who are in-network with your health plan:

More information about your rights and protections

Visit https://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 or services not covered due to a lack of prior authorization.

With my signature, I am saying that I agree to get the items or services from one of the providers at Singer Dermatology. This will include office visit charges and procedures. If a secondary facility such as a lab or pathology service is going to be utilized, you will have an opportunity to review a good faith estimate by the provider at the time of service to decide if you wish to proceed with this.

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'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 have to pay out-of-network
  cost-sharing under my health plan.

- I was given a written notice on today's date (on signature page) 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

_____ Print name of patient

_____ Date and time of signature

_____ Guardian/authorized representative's signature

_____ Print name of guardian/authorized representative

_____ 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.

More details about your estimate

Patient name:

Estimates:

Return visit to office: $75

New visit to office: $200

Botox for hyperhidrosis (sweating): $900

Cosmetic services otherwise are always billed as cash and the cost will be given at the time of service.

If you require a biopsy, bloodwork, or culture, and you do not have a referral and you are agreeing to being seen today, we will also provide you a good faith estimate before doing the procedure.

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.