

## Surprise Billing Protection Form

**This purpose of this document is to let you know 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 aren't required to sign this form and shouldn't sign it if you didn't 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 isn't 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 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 get emergency care from out-of-network providers and facilities, or
- When an out-of-network 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 **shouldn't** sign this form if you **didn't** 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 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.



Diplomates, American Board of Neurological  
Surgery  
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## Estimate of what you could pay if you give up your protections

Patient name: \_\_\_\_\_

Out-of-network provider(s) or facility name: Fort Worth Brain & Spine Institute, LLP

Total cost estimate of what you may be asked to pay:	
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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 Mairajeannett Guadalupe, with FWBSI, LLP at (817) 878 - 5333 or at FWBSI.com for a representative of the provider to explain the documents and estimates to the patient and answer any questions, as necessary.

▶ Questions about your rights? Contact the Texas Department of Insurance (relating to State Regulated Health Plans – Website: <https://www.tdi.texas.gov/tips/texas-protects-consumers-from-surprise-medical-bills.html> and telephone number 1-800-252-3439.

Contact the Centers for Medicare and Medicaid Services (relating to all other health care coverages) – Website: <https://www.cms.gov/nosurprises>. The Federal phone number for information and complaints is 1-800-985-3059.

### Prior authorization or other care management limitations

*[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

\_\_\_\_\_.

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.]

*[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*



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**Understanding your options**

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

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**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 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):

- [doctor’s or provider’s name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*
- [facility name]*

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:

- 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 on *[enter date of notice]* that explained my provider or facility isn’t in my health plan’s network, described the estimated cost of each service, 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 might not treat you, but you can choose to get care from a provider or facility that’s in your health plan’s network.**

	or	
Patient’s signature		Guardian/authorized representative’s signature
Print name of patient		Print name of guardian/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.**



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## More details about your total cost estimate

Patient name: \_\_\_\_\_

Out-of-network provider(s) or facility name: Fort Worth Brain & Spine Institute, LLP

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't 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 if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

*[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.]*

*For each provider or facility described in the notice, fill-in the table below by completing each column for each item and service to be provided by the provider or facility. Add additional rows if necessary. If the notice is for more than one facility or provider, list items and services to be provided by the same facility or provider in adjacent rows, and provide a subtotal estimate for each facility and provider(s). If the notice is for one facility or one provider, the subtotal estimate may be omitted. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]*

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
Subtotal for [insert name of provider or facility]:				
Total estimate of what you may owe:				