

Arne Wellness 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 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 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 **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.

BALANCE BILLING RIGHTS

Our office and providers are **not** "in network" with all insurer or benefit plans. When an out-of-network provider bills the difference between what an insurer decides is the eligible charge for a covered service and what the provider bills as the total charge, it is referred to as "surprise" or "balance" billing. Laws protect against such billing when a person receives **emergency services** or **unintentionally receives covered non-emergency services from an out-of-network provider at an in-network facility**. In such circumstances, the most you can be billed is your plan's in-network cost-sharing amounts (copays, deductibles, out of pocket limits) and you cannot be balance-billed. Specifically:

EMERGENCY SERVICES: If you receive covered emergency services, in many circumstances, the most you can be billed is your plan's in-network cost-sharing amounts and you cannot be balance-billed. Our office and providers do **not** provide emergency services.

NONEMERGENCY SERVICES: At an in-network facility, you have the right to request that in-network providers perform all covered services; however, you may have to receive services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance) and you cannot be balance billed. When you intentionally receive care at an out-of-network facility or from an out-of-network provider you may be balance billed. Our office and providers are **not** "in network" with any health plans, so if you receive care, you are intentionally receiving out of network care.

ADDITIONAL PROTECTIONS: Your insurer may pay out-of-network providers and facilities directly for covered services and must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit. Providers and facilities must refund any amount you

overpay within 60 days of notice. No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

Estimate of what you could pay

Patient Name: _____

Out-of-network provider(s) or facility name: Arne Wellness Center; Robert Arne, DC; Serena Elhard, DC and Jake Duerksen, DC

Total cost estimate of what you may be asked to pay:	
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- ▶ **Review your detailed estimate.** See the detailed cost estimate for each item or service you'll 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?** Or, If you think that you have received a bill in error, you want to file a complaint, or have further questions, you can submit complaints or questions to:

Robert Arne, DC
arnewellnesscenterco@gmail.com
303-948-9998

- ▶ **Questions about your rights?** Call Colorado Department of Insurance: 303-894-7499

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.

More information about your rights and protections: Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Note: Doctors of chiropractic are not permitted to opt out of Medicare; however, Medicare does not cover most chiropractic care. Accordingly, beneficiaries accept full responsibility for paying charges for uncovered services.

When you intentionally receive nonemergency services from an out-of-network provider, you may be balance billed and be responsible for the entire bill. It is your responsibility to know your health benefits and coverage limitations.

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 Arne Wellness Center and all providers, including:

Robert Arne, DC Serena Elhard, DC Jake Duerksen, DC

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 _____ 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's signature

or _____
Guardian/authorized representative's signature

Print Name of Patient

Print Name of Guardian/authorized representative