the ART ROOM
CENTER FOR CREATIVE HEALING

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 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 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.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: The Art Room Center for Creative Healing, LLC

Total cost estimate of what you may be asked to pay:	$200 for the intake/ $175 per session

❏ **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 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?** Visit www.cms.gov/nosurprises or Call 1-800-985-3059.
❏ **Questions about your rights and protections under federal law?** Contact CMS at www.cms.gov/nosurprises or 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 an item or service before you get them. If prior authorization is required, ask your health plan about what

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:

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): _____ The Art Room Center for Creative Healing, LLC

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 [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.

Client Signature | Client Name Printed | Date/Time

IF APPLICABLE: Guardian/authorized representative Name Printed | Relationship to Client

Guardian/authorized representative signature | Date/Time

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: _____

Out-of-network provider(s) or facility name: The Art Room Center for Creative Healing, LLC

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 how much, if any, your plan will pay and how much you may have to pay.

Date of service	**Service code**	**Description**	**Estimated amount to be billed** (individual/Family)
As needed	90791	75 min Therapy Intake/Evaluation *required for all new clients or clients who've been discharged and are returning to services after 6+ months.*	$175/$200
As needed	90834	40-45 min session	$120/$150
As needed	90837	50-55 min session	$150/$175
As needed	90853	Group Therapy	$50
As needed	90846	Family therapy without client	$175
As needed	90847	Family therapy with client	$175
As needed		30 minute Parent Check-in	$90
Total estimate of what you may owe:			$200 per session