Right to Receive a Good Faith Estimate of Expected Charges Under the No Surprises Act

Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act (part of the Consolidated Appropriations Act of 2021) and Surprise Billing Protection Consent Form

Under Section 2799B-6 of the Public Health Service Act, beginning January 1, 2022, health care providers and health care facilities are required to inform individuals both orally and in writing of their right to receive a "Good Faith Estimate" of expected charges. The No Surprises Act is designed to protect patients from receiving unexpected medical bills.

You are receiving this notice because your provider and/or our office is not in your health plans network and does not have an agreement with your insurance plan. The purpose of this document is to let you know about your protections from unexpected medical bills. By signing this form, you are consenting to giving up those protections and pay more for out-of-network care. You are not required to sign this form and should not sign this form 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 plans network, which may cost you less. If you would 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.

If your plan covers the item or service you are 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.

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. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility.

You have the right to receive a "Good Faith Estimate" explaining how much your care at Gulfshore Behavioral Health will cost, prior to your appointment(s). Under the law, health care providers need to give patients who do not have insurance or who are not using insurance, an estimate of the bill for medical items and services. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. For questions or more information about your right to a Good Faith Estimate, visit: www.cms.gov/nosurprises.

Agreement: I understand that: a) I had a choice of providers when receiving care and chose to continue with a provider at Gulfshore Behavioral Health that is out-of-network with my health plan, b) I am giving up my protections under the law, and c) I may pay more by owing the full costs billed for items and services rendered because my health plan may not count what I pay to GSBH towards my health plan's deductible and out-of-pocket limit.

By signing this form, I consent to receiving services at Gulfshore Behavioral Health and agree to all of the above.