KANE COUNTY COUNSELING SERVICES, LLC
DBA BARNUM COUNSELING
3833 E. MAIN STREET, UNIT #2120 - SAINT CHARLES, IL 60174
alisha@barnumcounseling.com
www.barnumcounseling.com

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

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.

Estimate of what you could pay if you give up your protections

Patient Name:_____

Out-of-network provider(s)or facility name: BARNUM COUNSELING

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

►Review your detailed estimate. **See "Good Faith Estimate" 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 Anna Forth at 630-797-9192 x.0.

►Questions about your rights? Contact 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 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.

Understanding your options

You can get the items or services described in this notice from other providers who are in-network with your health plan. Contact your insurance plan today for a list of in-network providers.

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care.

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 Barnum Counseling

_____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 _____ 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.