

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 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 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 is not 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.

HUDSON HEADWATERS HEALTH NETWORK SERVES ALL PATIENTS.

For a complete list of our charges and financial services available to you, please visit <https://www.hhnh.org/about/patient-financial-services/>. You can also contact our patient support services team at 518-761-0300, ext. 31400, between 8:00am and 4:30pm. For dental billing questions, please call 518-623-3918. See the next page for your cost estimate.



9 CAREY ROAD
QUEENSBURY, NY 12804
518-761-0300
WWW.HHHN.ORG

Estimate of what you could pay

Patient name: _____

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

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 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?** If you have questions about Hudson Headwaters billing and fees, or if you would like to discuss setting up a budget/payment plan, please call our patient support services team at 518-761-0300, ext. 31400, between 8:00 a.m. and 4:30 p.m. For Dental billing questions please call 518-623-3918.

► **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.

Understanding your options

You may be able to receive items or services described in this notice from these providers who are in-network with your health plan, please contact your insurer for assistance.

At Hudson Headwaters Health Network, we believe that no one should delay seeking needed medical care because they lack insurance or have high medical costs. That's why we offer discounts and payment plans to eligible patients.

We offer a Sliding Fee program that discounts your costs for medical and dental care at our health centers (including primary and specialty care, many dental services, prescriptions and x-rays). You may be eligible for the program even if you have insurance. Please visit

<https://www.hhhn.org/about/patient-financial-services/> or contact our Sliding Fee Program staff by phone at 518-824-8640, or by email at SFPRxAssist@hhhn.org.

More information about your rights and protections

► If you have questions about your rights, please visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information.



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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):

- [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 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 must 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 **do not** 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

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 estimate

Note this is a generic estimate based on the primary reason for your scheduled visit. 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 only. 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. If you would like to discuss setting up a budget/payment plan, please call our patient support services team at 518-7610300, ext. 31400, between 8:00am and 4:30pm.

Patient name: _____

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

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.

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. 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	Service code	Description	Estimated amount to be billed
Total estimate of what you may owe:			

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.