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

Out-of-network provider(s) or facility name: Cornerstone Physical Therapy

Total cost estimate of what you may be asked to pay:	$300 Evaluations /$210 per hour visit thereafter

►**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?** Call Cornerstone Physical Therapy 301-732-4754.

►**Questions about your rights?** Contact Insurance Administration of Maryland Toll Free: (800) 735-2258 Local: (410) 468-2000 Web Site: https://www.mdinsurance.state.md.us/

Or Health and Human Services (301) 624-7907

Or www.cms.gov/nosurprises

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 can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

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

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):

- [x] James Bucklin NPI# 1750440673
- [x] Hayley Murphy NPI# 1457728545
- [x] Lynne Schill NPI# 1558318113
- [x] Joshua Neer NPI# 1568144137
- [x] Rachel Kenawell NPI# 1467820456
- [x] Margaret McPherson NPI# 1437986775
- [x] Cornerstone Physical Therapy Tax ID# 83-2284956

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 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.

_____ or _____

Patient's signature

Guardian/authorized representative's signature

_____

Print name of patient

_____

Print name of guardian/authorized representative

_____

Date of Birth

_____

Date

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

Out-of-network provider(s) or facility name: Cornerstone Physical Therapy_Tax ID# 83-2284956

James Bucklin NPI# 1750440673 Hayley Murphy NPI# 1457728545 Joshua Neer NPI# 1568144137

Lynne Schill NPI# 1558318113 Rachel Kenawell NPI# 1467820456

Margaret McPherson NPI# 1437986775

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.

$300 Evaluation

Date of service	Service code	Description	Estimated amount to be billed
Initial Evaluation per case	97161	PT evaluation – low complexity	
	97162	PT evaluation – moderate complexity	
	97163	PT evaluation – high complexity	
		Total estimate of what you may owe:	**$300**

$210 Each 1-hour subsequent visit

Date of service	Service code	Description	Estimated amount to be billed
Each subsequent visit associated to a single case.	97164	PT re-evaluation	
	97110	Therapeutic exercise	
	97112	Neuromuscular re-education	
	97116	Gait training	
	97530	Therapeutic activity	
	97535	Self-care/home management training	
	97140	Manual therapy	
		Total estimate of what you may owe:	**$210**