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

Patient name: ____

Out-of-network provider(s)or facility name: Rachel Bédard, PhD LLC__

Total cost estimate of what you may be asked to pay:	$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?** Call Dr. Bédard at 970-391-9628 or visit www.DrRachelBedard.com

►**Questions about your rights?** Contact https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-health-care

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 https://www.hhs.gov/regulations/index.html 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):

☐ Dr. Rachel Bédard

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 _______ (date) 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 and time of signature

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: Dr. Rachel Bédard, PhD 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.

Service code	Description	Estimated amount to be billed
90834	45-minute individual therapy appointment	$175
90832	25-minute individual therapy appointment	$115
--	45-minute Autism Consultation	$175

FINANCIAL OBLIGATIONS

Dr. Bédard accepts the following forms of payment:

- **Cash**
- **Check**
- **Credit card/HAS cards**

Payment for therapy services is due before or at the time of your session. Dr. Bédard reserves the right to potentially cancel your appointment or suspend the provision of therapy services due to an outstanding balance until the balance is paid.

An administrative fee of $100 may apply to any balances extending beyond 30 days.

All clients are advised that your full appointment fee may be charged for any missed appointments or appointments that are canceled less than 24 hours in advance.

In the event disclosure of your records and/or Dr. Bédard's testimony is requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you may be responsible for and shall pay the costs involved as indicated below. This may include but is not limited to copying/sending records, traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time Dr. Bédard provides services to you. Dr. Bédard reserves the right to require a deposit for anticipated court appearances and/or preparation required on your behalf.

INSURANCE

- **Insurance Coverage.** Dr. Bédard is not on any insurance panels. All services are considered Out of Network and you are considered a Private Pay client.

PRIVATE PAY FEE SCHEDULE

- 45-minute appointment is $175
- 25-minute appointment is $115

- **Other Hourly Rates**

- Phone Consultation: $175/45 minutes
- Court Testimony: $300/hr (10 hrs min payable in advance);
- Consultation: $175/45 minutes (such as IEP meeting, record review/correspondences);
- Paperwork: $175/45 minutes flat fee;
- Medical records: $100 flat fee.

If there are pending court cases that will require a court appearance by Dr. Bédard, you are required to submit a $3000 fee in advance for these services 30 days prior to the court date.

Please note, by signing this Informed Consent, you agree to all fees for services owed to Dr. Bédard, as well as any other fees, all of which are detailed within this Informed Consent.

____ or ____

Patient's signature Guardian/authorized representative's signature

____ ____

Print name of patient Print name of guardian/authorized representative

____

Date and time of signature