SURPRISE BILLING PROTECTION FORM – FOR OUT OF NETWORK AND SELF-PAY CLIENTS

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.

Estimate of what you could pay

Out-of-network provider(s) or facility name: Align Wellness Solutions

Your first session will cost up to $150, depending on your provider and whether you have discussed a lower sliding scale fee. Some of our providers are newly licensed clinicians (APC, LMSW, AMFT) and still under supervision of a more senior licensed clinician. The standard rate for these clinicians is $120 per session. Fully licensed clinicians (LPC, LCSW, LMFT) have a standard rate of $150 per session. At or before this first session, your provider will create for you a Good Faith Estimate, which will include your agreed upon rate, and an estimate of the total cost for sessions annually.

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

►You will receive a separate form from your therapist with a cost estimate specifically for you.

►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? Contact Align Wellness owner, Melanie Storrusten at melanie@alignwellnessatl.com

►Questions about your rights? Contact the Department of Health and Human Services http://www.hhs.gov and the Center for Medicare Services http://www.cms.gov

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.

More information about your rights and protections

Visit http://www.hhs.gov 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):

Align Wellness Solutions Clinicians - your specific, independently contracted clinician will be listed on your Good Faith Estimate.

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 or before the date of my first appointment 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.