Delaware Pediatrics, LLP
"making it all better"

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 are not required to sign this form and should not 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. Keep a copy of this form for your records.

You're getting this notice because this provider/facility isn't in your health plan's network (meaning the provider/facility doesn't have an agreement with your plan) or your child (ren) currently do not have active insurance.

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.

Delaware Pediatrics, LLP
"making it all better"

Estimate of what you could pay

Patient (s) name: ___________________________________ **DOB (s):** ______________________

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

____

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

- 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 716-884-0230 and ask for the Billing Department.
- Questions about your rights? Contact NY State Department of Finance (800) 342-3736.

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 by calling them requesting for in-network pediatricians.

More information about your rights and protections

Visit https://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):

Please choose rendering Provider:

☐ Taylor Amico, FNP
☐ Anthony Caterina, MD
☐ Erin Diebold, PA
☐ Steven Lana, MD
☐ Katherine Luce, MD
☐ Nate Manna, PA
☐ Carol Northrup, FNP
☐ Robyn Steinacher, DO
☐ Linda Stockmeyer, FNP
☐ Joyce Zmuda, MD

Facility:
☐ Delaware Pediatric Associates

Delaware Pediatrics, LLP
"making it all better"

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 am 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 ___________ explaining that my provider or facility isn't in my health plan's network, or I do not have any active insurance, 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.

I agree that if Delaware Pediatric Associates treats my child (ren), I will be responsible for payment on all charges.

____

Patient/Parent/Guardian/authorized representative's signature

____

Print name of patient/parent/guardian/authorized representative

____

Date and time of signature

____ ________________________________

Witness signature **Date**

Keep a copy of this form. It contains important information about your rights and protections.

More details about your estimate:

Patient (s) name: ___________________________________ **DOB (s):** ____________________

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

____

The amount below is only an estimate; 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.

Listed below is the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.

Date of Service	CPT Code	Description	Estimated Amount Billed
		Total Estimate of what you may owe:	$

Name of who is providing estimate: ______________________________ **Date:** ______________

The estimated costs are valid for calendar year from date of the "Good Faith Estimate."