KernMedical

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections against unexpected medical bills and if you'd like to give up those protections and pay more for out of network care.

I**MPORTANT**: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider at the time of receiving care. You can choose to get care from a 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 are getting this notice because this facility isn't in your health plan's network and is considered out-of-network. This means the facility doesn't have an agreement with your plan to provide services. **Getting care from this facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill. Ask your health care provider or patient advocate if you are not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

Before deciding whether to sign this form, you can contact your health plan to find an in-network facility. If there isn't one, you can also ask your health plan if they can work out an agreement with Kern Medical Center to lower your costs.

SURPRISE BILLING PROTECTION FORM

KernMedical

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from Kern Medical Center:

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice that explained my facility is not in my health plan's network, described the estimated cost of services, and disclosed what I may owe if I agree to be treated by this facility.
- I received the notice either on paper or electronically (circle which option), consistent with my choice.
- I fully and completely understand that some or all of the 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 facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this facility might not treat you (excluding emergency care services, you can however choose to receive non-emergency care from a facility that's in your health plan's network.)

_____

Patient's signature Guardian/authorized representative's signature

_____

Print name of patient or Print name of guardian/authorized representative

_____ _____

Date Time

A copy of this signed form will be given to you for your records. It contains important information about your rights and protections.

Patient Access- 5/2023