Lexi Alberts, MSW, LICSWA

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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.

Lexi Alberts, LICSWA is an out-of-network provider. You're getting this notice because this provider isn't in your health plan's network. This means Lexi Alberts, LICSWA doesn't have an agreement with your plan.

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.

Getting care from this provider or facility could cost you more than if you were to see a provider in-network.

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 Lexi Alberts, LICSWA 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

Patient Name:_____

Out of Network Provider Name: Lexi Alberts Counseling, LLC

Total Cost of Estimates of what you could be asked to pay over the course of treatment (this is your individual session cost multiplied estimated costs of sessions over 6 months):

See Good Faith Estimate & Disclosure Document that Lexi Alberts, LICSWA provided More Details

What To Do Next

▶**Review your detailed estimate.** This is in this document and also in the Good Faith Estimate and Disclosure Document that Lexi Alberts, LICSWA provided.

▶**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 Lexi Alberts, at 360-207-

4365

▶**Questions about your rights?** 1-800-985-3059. For more information about your rights and protections, visit *www.cms.gov/nosurprises/consumers*

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 receive services from Lexi Alberts Counseling, LLC.

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 will be listed in your individual estimate) explaining that my provider 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.

- 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.

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.

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 service may be difference 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.

Date of Service	Service Code	Description	Estimated Amount to be Billed

Total estimate of what you may owe $_____