GARDENS NEUROLOGY SELF-PAY AGREEMENT FORM

This form is provided to you today as an acknowledgment of your request to be seen by our office as a self-pay patient. A self-pay patient elects to personally pay in full for his/her care on the date of service due to their establishing contact with our office and presenting themselves as self-pay. All fees for self-pay services must be paid on the date of service for both office visits and testing. Your self-pay amount covers ONLY the professional services provided by us on that date of service. If you have any type of coverage, services received today will not be submitted by us to any insurer on your behalf, and will most likely not be reimbursed by your carrier or applied towards your deductible when you submit it.

By initialing and signing below, I acknowledge that I have read and understood the terms of this self-pay visit and have been given the opportunity to ask questions. I confirm that I am the patient (or the patient's authorized representative). I attest that:

_____ I have chosen Gardens Neurology and their treating providers and technicians to take care of my neurological needs. Whether it is a single visit, or multiple follow-up visits, I will be a self-pay patient until I inform the office otherwise. I understand my right to make personal payments for medical services provided to me here.

_____ The office provided me with a good faith estimate of today's cost for the visit and I agree to pay $____ for today's appointment. I realize that an insurer's in-network fee might be 50% less than this price.

_____ I was informed of the fee for today's visit when I scheduled this appointment – more than 72 hours ago. When scheduling this appointment, the office informed me of other possible reimbursable options.

_____ I am aware of the self-pay fee and am not surprised at the total amount which is indicated above.

_____ I might be covered/insured elsewhere or enrolled in a plan that Gardens Neurology does NOT accept.

_____ I will NOT submit this bill to be reimbursed by an insurance company.

_____ I understand all other terms that go along with the visit (those are stated in my new patient forms.)

_____ I understand that orders sent to other facilities may not be reimbursed and that the providers at Gardens Neurology are NOT responsible nor liable for any issues that may arise.

Name:_____ Date of Birth:_____

Signature:_____ Today's date:_____

This document is not part of the legal medical record

Gardens Neurology Self Pay Pricing

Medical

New Patient Appointment with the doctor: $450

Follow Up with the doctor: $250

Family Visit with the doctor: $180

Follow Up with the APRN: $175

Family Visit with APRN: $150

Cognitive Exam with APRN: $200

Quality Measures/Care Plan with APRN: $275

EMG 1 limb (including nerve conduction study) $375

EMG 2 limbs (including nerve conduction study) $475

EMG 3 limbs (including nerve conduction study) $600

EMG 4 limbs (including nerve conduction study) $700

EEG (routine, up to 40 minutes, including reading) $460

EEG (extended/sleep deprived up to 60 min, inc. reading) $550

Administrative

Medical Records: $1 per page plus shipping (only our records)

No Show fees - New Patient and Testing: $100 Follow Ups: $75

Yearly Membership: $350

After Hours Care fee: $250

Prices may vary depending on case outcomes and urgency. Any price changes will be communicated, when possible, in advance or at the time the appointment is made.

OMB Control Number: 0938-1401
Expiration Date: 03/31/2022

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary's specifications regarding the form and manner of the notice and consent documents.

These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law. To use these documents properly, the nonparticipating provider or facility must fill in any blanks that appear in brackets with the appropriate information. Providers and facilities must fill out the notice and consent documents completely and delete the bracketed italicized text before presenting the documents to patients.
In particular, providers and facilities must fill in the blanks in the "Estimate of what you may pay" section and the "More details about your estimate" section before presenting the documents to patients.

The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents. The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary. The documents must meet applicable language access requirements, as specified in 45 CFR 149.420. The provider or facility is responsible for

translating these documents or providing a qualified interpreter, as applicable, when necessary to meet those requirements. The standard notice must be provided on paper, or, when feasible, electronically, if selected by the individual. The individual must be provided with a copy of the signed consent document in-person, by mail or via email, as selected by the individual.

If an individual makes an appointment for the relevant items or services at least 72 hours before the date that the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, at least 72 hours before the date that the items and services are to be furnished. If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these notice and consent documents must be provided to the individual, or the individual's authorized representative, on the day the appointment is scheduled. In a situation where an individual is provided the notice and consent documents on the day the items or services are to be furnished, including for post-stabilization services, the documents must be provided no later than 3 hours prior to furnishing the relevant items or services.

NOTE: The information provided in these instructions is intended to be only a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the standard notice and consent documents given to patients.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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: Gardens Neurology

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

► **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 Gardens Neurology at 561-799-2831 with any questions relating to this upcoming visit, estimates, or documents.

► **Questions about your rights?** Contact the Federal Consumers Protections agency with any further questions.

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 providers who are in-network with your health plan. In order to receive an updated list of providers, please contact your insurer.

More information about your rights and protections

Visit 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):

☐ Dr. Silvers ☐ Dr. Brooks ☐ Frances Casillas, APRN ☐ EEG

☐ Gardens Neurology

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 (fill in date of receipt of this notice) _____ 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. More than 24 hours' notice ahead of scheduled appointment is necessary when cancelling.

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 | 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: Gardens Neurology

_____

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.

See details below for a list of estimated services on the scheduled dates of service.

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	