Trinity Health

Acknowledgment of Financial Responsibility (Waiver) for Non-Covered In-Network Services & Office-only Services Provided by an Out-of-Network Provider / Notice to Uninsured & Self-Pay Regarding Right to Receive a Good Faith Estimate

SECTION 1

Location Date of Service

Patient Name Date of Birth Guarantor Name

In-Network

I understand that even if my provider is in network with my health coverage, service(s) provided to me may or may not be paid by my insurance company for any of the following reasons:

- Authorizations, referrals, pre-certifications are not a guarantee of payment
- My insurance coverage cannot be verified at this time (i.e. Insurance closed)
- Insurance carrier's demographic information is wrong or does not match IHA records
- Coordination of benefits issue identified by my insurance company
- Newborn not added to policy
- I am assigned to a different PCP
- VFC:
  - I elect to waive participation with the VFC Program
  - I choose to enroll with the VFC Program, and I agree to pay the administration fees
- DME Supplies are self-pay only. DME sales are final, no returns or exchanges

Out of Network

☐ State law provides protections for in-office services provided out of network if I am not first advised that my provider is out of network. I have been advised to seek an in-network provider. State and federal law provide protections that limit the amount I will be required to pay for emergency services and certain services in a facility or related to a facility visit.

PLEASE INITIAL

If permitted by applicable law, I agree to pay out of pocket costs that could be higher than if I were to have services from an "in network" provider.

I agree that I have been advised that the service(s) I am requesting and that will be provided to me will be considered out of network and may not be covered services and may or may not be paid by my health coverage/insurance company.

Services: _____

_____

_____

Out of Network Disclaimer

- Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.
- You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.
- The nonparticipating provider must provide a good faith estimate of the cost of the health care services to be provided. This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
- The Good Faith Estimate does not include any unforeseen, unknown or unexpected circumstances/costs that may arise during treatment which may affect the cost of the health care services provided. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.
- The Good Faith Estimate does not obligate or require you to obtain any of the listed services from the provider.

☐ Good Faith Estimate Provided - By signing below, I acknowledge that I have received, read, and understand the out of network disclosure above and have received a good faith estimate. I understand that if permitted by applicable law I will be financially responsible for payment of all services provided that are not paid by my health coverage/plan or that I have chosen to self-pay.

PLEASE INITIAL

_____

Patient Signature Date

Parent or Legal Guardian Signature Relationship to patient Date

_____

(Type or print name of patient or patient's representative)

Patient/legal guardian declines to sign: Complete **SECTION 1** and the following:

PATIENT/LEGAL GUARDIAN DECLINED: _____ STAFF INITIALS: _____

Date

FEB 2022

No Surprises Act Self-Pay Good Faith Estimate Notice

If you are **uninsured** or **choosing to self-pay** for the health care services you're receiving, you have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1800-985-3059.