Mandalyn Castanon, LMHC, LPCC
2575 E. Perrin Ave., Fresno, CA 93620
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THE NO SURPRISES ACT STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

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 did not 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 are receiving this notice because this provider or facility is not in your health plan's network. This means the provider or facility does not 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 are 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 may not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **should not** sign this form if you **did not** have a choice of providers when receiving care. For example, if a doctor as 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 next page for your cost estimate.

Estimate of What You Could Pay

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Patient Name:_____

Out-of-Network Provider (s) or Facility Name:____Mandalyn Castanon, LMHC, LPCC_____

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see a breakdown of possible fees on page four (4).

- ➔ **Review your detailed estimate.** See page four (4) for a cost estimate for reach item or service.
- ➔ **Call your health plan.** Your health plan may have better information about how much of these services are reimbursable.
- ➔ **Questions about this notice or estimate?** Call Mandalyn Castanon at 765-896-5030.
- ➔ **Questions about your rights?** Contact:

Office of the Indiana Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) 317-233-4393 (fax)
www.IndianaConsumer.com

- ➔ **California Residents:** For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (800) 985-3059.

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, as your health plan about what information is necessary to get coverage.

More information about your rights and protections

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.