

Michael F. Shea, LICSW, LLC
2311 M Street, NW Suite 304
Washington, DC 30037
(202) 966-0575

THE “NO SURPRISES ACT”
STANDARD NOTICE
(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.

You are getting this notice because I am not a provider in your health plan’s network. This means I do not have an agreement with your health plan to provide services.

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 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 should not sign this form if you did not 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 is not one, your health plan might work out an agreement with this provider or facility, or another one. (See page 4 for your cost estimate).

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 review your cost estimate for each service. Call your health plan as your plan may have better information about how much of these services are reimbursable.

Questions about this notice and estimate? Please discuss with me.

Questions about your rights? If you believe you've been wrongly billed or your health plan has improperly processed your claim, call or email us for more information, or file a complaint here:

Health Education and Advocacy Unit
Office of the Attorney General
District of Columbia
400 Sixth Street, NW
Washington, DC 20001
Fax: (202) 347-8922
TTY: (202) 727-3400
Email: oag@dc.gov

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.]

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.

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THE “NO SURPRISES ACT”
CONSENT DOCUMENT

By signing, I give up my federal consumer protections under the No Surprises Act and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to receive services provided by Michael F. Shea, LICSW.

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 am giving up some consumer billing protections under Federal law.
- I may get a bill for the full charges for these items and services or must pay out-of-network cost sharing under my health plan.
- I received a written notice on _____ explaining that my provider is not 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.

IMPORTANT: You do not have to sign this form. But if you do not sign, this provider might not treat you.

Patient’s signature or Guardian/authorized representative’s signature

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

Date of signature

Keep a copy of this form.
It contains important information about your rights and protections.