GRANGER ORAL SURGERY
& DENTAL IMPLANTS
Taite R. Anderson, DDS
Board-Certified Oral and Maxillofacial Surgeon

Surprise Billing Protection Form
The purpose of this document is to let you know about your protection 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 plans 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 services 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 protection 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 next page for your cost estimate.

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Estimate of what you could pay
Patient name:
_____
Out-of-network provider(s) or facility name:
_____

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 Granger Oral Surgery's Insurance Department.

- **Questions about your rights?** Contact an appropriate federal or state agency. The federal phone number for information is 1-800-985-3059

Prior authorization or other care management limitations
Except in an emergency, your health plan may require prior authorization (or limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or services 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 these providers who are in-network with your health plan.

More information about your rights and protections
Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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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:

- € Dr. Taite R. Anderson
- € Granger Oral Surgery & Implants
- € St Joseph Regional Medical Center
- € Anesthesia

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 ___/___/___ explaining that my provider of facility isn't in my health plans 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 **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

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More Details about your estimate
Patient name: _____

Out-of-network provider(s) or facility name:
_____
The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated cost 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.**

Date of service	Name of Provider or Facility	Service Code	Description	Estimate amount to be billed
Total estimate of what you may owe:				