Estimate of what you could pay

Patient Name:_____

Out-of-network provider(s)name:_____

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

- **Review your detailed estimate.** See page 3 for a cost estimate for each item or service you will 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 973-599-9779.
- **Questions about your rights?** Contact cms.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 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.

Understand your options

You can also get the items or services described in this notice from these providers who are in-network with your plan:

More information about your rights and protections

Visit cms.gov

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):

_____ (Provider)

Atlantic Orthopaedic Associates

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 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 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.

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 name | Guardian/authorized representative's signature

_____

Date and time of signature

Take picture/or keep a copy of this for.
It contains important information about your rights and protections

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 estimate 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 that 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.

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