



## Surprise Billing Protection Form

Ways of Play Counseling Services LLC 5377 State Highway N Cottleville, MO 63304 –  
[www.waysofplay.com](http://www.waysofplay.com) – 636.344.0580

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 potentially pay more.

**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. Take a picture and/or keep a copy of this form for your records. If you choose to not sign, your provider or facility might not treat you.

You're getting this notice because this provider does not accept insurance or you are choosing to pay out of pocket. Getting care from this provider or facility could cost you more. If you have insurance, your plan may cover the services you're getting, federal law protects you from higher bills.

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.

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.

**YOU CAN REQUEST AN ESTIMATE AT ANYTIME.** This estimate will detail diagnosis, frequency of visits and possible duration of treatment. Please note that your diagnosis will be recorded and kept as part of your client chart for up to 7 years. Speak to your clinician should you have any questions. Due to the nature of therapy, exact length of therapy is variable and may change. You have the right to terminate treatment at any point.

What's next:



- ▶ Request and review your detailed estimate.
- ▶ Questions about covered services? 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 **Marie Bonner-Horon 636.344.0580**
- ▶ Questions about your rights? Contact **Missouri Department of Insurance at 800-726-7390 or The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227).**

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 or offer different prices for similar services.

More information about your rights and protections Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

By signing, I understand that I am paying out of pocket by choice and have discussed the potential cost of services with my provider. 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

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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.
- I was given a written notice explaining that my provider's cost for 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.

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