Custom Care Rehab
Mobile Physical Therapy

No Surprise Billing Protection Form

In Compliance with a new federal regulation, Custom Care Rehab is an out of network healthcare choice and we are providing you with the following estimate of cost of care. 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 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 plan's 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 service 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 healthcare 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 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 the next page for your cost estimate.

Estimate of what you could pay

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

►Review your detailed estimate below 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 Custom Care Rehab at 330-618-5703

►Questions about your rights? Contact CMS.gov or CMS

Prior authorization or other care management limitations

There may be prior authorization requirements for an individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or 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. Understanding your options You can also get the items or services described in this notice from these providers who are in-network

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with your health plan: More information about your rights and protections Visit CMS.gov for more information about your rights under federal law.

Estimate of what you could pay

Patient name/ DOB:_____
Out-of-network Facility: _Custom Care Rehab ____(Tax ID 85-0864649) ____(NPI 1619598778)_____
Total Cost of what you may pay: _____See Cost Chart Below_____

Pricing & Packages:

Services		Sessions		Total
Initial Assessment and Treatment		1		$185
Single sessions		1		$155
Therapy Packages		3		$436
		6		$855
		9		$1,260
		12		$1,675
		24		$3,350

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: X Custom Care Rehab

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 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.

_____ Patient's or Guardian/authorized representative's signature
_____ Print name of patient or representative
_____ Date and time of signature

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