Out-of-Network No Surprises Act Consent Form

Elie Sader, MD, PLLC is an out-of-network provider, meaning that we do not have an agreement with your health plan's network. The purpose of this form is to notify you of protections you have from unexpected medical bills.

If your insurance plan covers the services you're receiving, 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.

By signing this form, you consent to giving up your federal consumer protections and agree to pay more for out-of-network care. Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

Before deciding whether to sign this form, you may 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, if the services fall under those within the No Surprises Act and outlined above.

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.

With your signature on this form, you agree to receive items or services from:

- **Elie Sader, MD**
- **Elie Sader, MD, PLLC**

By signing this form, you acknowledge that you are consenting of your own free will and are not being coerced or pressured. You understand that you:

- Are giving up some consumer billing protections under federal law.
- May receive a bill for the full charges of these items and services or have to pay out-of-network cost-sharing under your health plan.
- Were given a written notice on _____ explaining that our facility is not in your health plan's network, the estimated cost of services, and what you may owe if you agree to be treated by this provider or facility.
- Received the notice either on paper or electronically, consistent with your choice.
- Fully and completely understand that some or all amounts you pay may not count towards your health plan's deductible or out-of-pocket limit.
- May end this agreement by notifying the Practice in writing before receiving 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 receive care from a provider or facility in your health plan's network.

_____ _____

Patient's Signature Patient's Printed Name

_____

Date

Estimate of What Your Services Could Cost You

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated 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 than this estimate.**

Patient Name: _____

Out-of-Network Provider(s) or Facility Name: _____

_____

Date of Service	Service Code	Description	Estimated amount to be billed
TOTAL COST ESTIMATE OF WHAT YOU MAY BE ASKED TO PAY:			**$**_____

► **Questions about this notice and estimate?** Call Dr. Sader at (203) 635-8780.

► **Questions about your rights? Visit** https://www.cms.gov/nosurprises

► **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 is covered under your plan and your provider options.

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.

For more information about your rights and protections, visit:
https://www.cms.gov/nosurprises