OPTCI OSTEOPRACTIC PHYSICAL THERAPY OF CENTRAL INDIANA
ORTHOPEDIC AND PELVIC HEALTH SPECIALIST

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills from the No Surprises Act (NSA) that takes effect in 2023

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 before scheduling care. You can choose to get care from a provider or facility in your health plan's network.

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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost different than in-network. It could cost you more or less.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay a different amount than in-network because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

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Details About Your Total Cost Of Treatment

Patient name: (Print)_____

Facility Name:___Osteopractic Physical Therapy of Central Indiana, LLC_____

The amount below is not an estimate but the actual cost; it isn't an offer or contract for services. This shows the full costs of the items or services listed. It doesn't include any information about what your health plan may cover.

Contact your health plan with any questions about your policy, deductible, if any portion of these costs will be reimbursed, and how much will get applied towards your deductible.

	Service Code	Description	Cost
OPTCI Evaluation	97161	Evaluation	$_____
	97163	Complex Evaluation	$_____
OPTCI Treatment Plan	97110	Therapeutic Exercise.	$_____
	97140	Manual Therapy	$_____
		Total Cost	$_____

►**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'll 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?** Contact Dr. Julius Marayag , the owner of Osteopractic Physical Therapy of Central Indiana at 317-922-3316 to explain the documents and estimates to the individual and answer any questions, as necessary.

►Questions about your rights? Contact the federal phone number for information and complaints at: 1-800-985-3059

Understanding your options
You can get the items or services described in this notice from the following 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.

By signing, I understand that I'm giving up my federal consumer protections and may have to pay a different amount than in-network care.

With my signature, I'm agreeing to get the items or services from Osteopractic Physical Therapy of Central Indiana, LLC

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I have to pay the full charges for these items and services.
- I was given a written notice on at the evaluation that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed 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 of the amounts I pay may or may 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.

317-922-3316 : Tel.#
info@optci.com : E-Mail
www.optci.com : Web
11501 Cumberland Rd. Suite 400
Fishers, IN 46037

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IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____or_____

Patient's signature

Guardian/authorized representative's signature

_____ _____

Print name of patient representative

Print name of guardian/authorized

_____ _____

Date and time of signature

Date and time of signature

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

317-922-3316 : Tel.#
info@optci.com : E-Mail
www.optci.com : Web
11501 Cumberland Rd. Suite 400
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