Proof Physical Therapy & Performance
460 N Switzer Canyon Dr. #400, Flagstaff, AZ 86001
928-440-3106 info@proofpt.com
www.proofpt.com
info@proofpt.com

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

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 health care 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 last page for your cost estimate.

Estimate of what you could pay

Out-of-network provider(s) or facility name: Proof Physical Therapy & Performance, LLC

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

► **Review your detailed estimate.** See page five for a cost estimate for each item or service.

► **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.

► **Questions about this notice and estimate?** Call our office at 928-440-3106

► **Questions about your rights?** Contact: Arizona Department of Health Services 602-542-1025

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 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.

More information about your rights and protections

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from:

Proof Physical Therapy & Performance, LLC

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 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.

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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FEDERAL TAX ID: 81-1683795 **NPI#:** 1629480512

More details about your estimate

Out-of-network provider(s) or facility name: Proof Physical therapy & Performance, LLC

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**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress)
	97161	Initial Evaluation- Low Complexity	$82.50
	97162	Initial Evaluation- Mod Complexity	$82.50
	97163	Initial Evaluation- High Complexity	$150
	97164	Re-evaluation	$57.50
	97001	Therapeutic Exercise (15 min)	$22.50
	97140	Manual Therapy (15 min)	$22.50
	97530	Therapeutic Activity (15 min)	$22.50
	97016	Vaso pneumatic Device	$22.50
	97112	Neuromuscular Re-education (15 min)	$22.50
	97116	Gait Training (15 min)	$22.50
	Cancelation Fee	Your Therapist Requires a 24-Hour Cancelation Fee	$65
		Initial evaluation total: $150, follow up visit total: $90	
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns. **This Good Faith Estimate expires on 1/1/2023**	___x per week for ____ weeks.

Patient/ Guardian Signature: _____
Date: _____

Patient or Guardian Name (Please Print): _____
Date: _____

- 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.