Purpose: The No Surprises Act (NSA) was passed by Congress in 2020 to protect patients from surprise medical bills. The NSA's purpose is to address gaps in insurance coverage that can lead to unexpected bills when patients receive care from providers outside their network.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

No surprise billing: What is “balance billing” (sometimes called “surprise billing”)? This is when you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

Insurance: Insurance is a contract between you and your insurance company. It is your responsibility to understand your benefits and coverage before receiving any care from our office. It is also your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance. Managed care plans, Health Maintenance Organizations (HMO), or Preferred Provider Options (PPO) benefits vary from plan to plan. Insurance companies may deny payment or reduce benefits if medical care is obtained outside of the plan’s covered benefits. Please check with your insurance carrier or employer for clarification of coverage or need for referral before your appointment.

Payment Policy: Payment for services provided to you is ultimately your responsibility. Charges not covered by your insurance company are payable in full within 30 days of receiving the bill. Co-payments and non-covered services are to be paid at the time of service. Waiver of co-pays may constitute fraud under State and Federal law. Patients with delinquent accounts will be required to make a $100 payment towards their balance at the time of service. Patients with an outstanding balance of $1000 or greater will be asked to pay 10% of their balance. If you

are unable to make mutually agreeable payment arrangements, we can assist you in rescheduling your appointment. All returned checks from the bank for non-sufficient funds will be charged a $25.00 fee. Spears Pain & Rehab realizes that medical costs can be an unexpected expense. We will work with you to create reasonable payment plans if you are unable to pay your bill all at once. It is important that you let us know as soon as possible if you will have difficulty paying your bill.

Self-pay: Patients without insurance coverage, patients covered by insurance plans in which the clinic does not participate or patients without an insurance card on file with us. Deposits of $400.80 for New Patients and $$270.00 for Established Patients are due at the time of check-in. Prior to any additional services being rendered, self-pay patients are required to pay in full. It is never our intention to cause financial hardship on our patients, only to provide them with the best care possible with the least amount of stress. We are willing to work with you on a payment arrangement for the balance of our account if necessary.

Non-covered services: I understand that in the event that my insurance plan requires a referral from my Primary Care Physician, and I do not have the proper referral from my Primary Care Physician, to cover the services that I am requesting from Spears Pain & Rehab, I agree that I shall be responsible for the payment in full for any charges related to services provided to me or my dependent(s).

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I hereby authorize and direct my current and future insurance carrier(s), including Medicare, commercial insurance, and any insurance plan responsible for paying the medical bills for the reason for which I am seeking care at Spears Pain & Rehab, to issue payment directly to Spears Pain & Rehab for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. This assignment will remain in effect until revoked by me in writing.

“No show” policy: I understand that Spears Pain & Rehab has a cancellation/no-show policy, and that I will be charged $100 for any appointment I cancel or miss with less than 24 hours notice for any reason not listed in **Category A**. Spears Pain & Rehab requires a minimum of a 24 hour notice for cancellations, and you must show up to your appointment no later than 15 minutes after it is scheduled. Given that there are unforeseen circumstances in which you may be running late, you will not be charged a no show fee if you show for your appointment up to

15-30 minutes late in the case of events listed in **Category B**. However, if you show up for your appointment more than 15 minutes after it is scheduled, you will need to reschedule your appointment. If you show up 5 to 14 minutes after your scheduled appointment, there may be a chance that your appointment will need to be rescheduled. Examples of reasons for not showing up for your appointment that will result in a no-show fee are listed in **Category C**.

✳ **Category A: acceptable reasons for missing your appointment without any notice**

- You are hospitalized and are able to provide documentation to confirm that this is true
- You are experiencing a medical emergency and provide emergency medical documents proving that you were experiencing a medical emergency
- You have a dependent (such as a child or disabled adult) who is experiencing a medical emergency and are able to provide emergency medical documents proving this to be true
- You are admitted to a psychiatric or drug rehabilitation care facility and able to provide documentation upon request
- You are unexpectedly admitted to an inpatient rehabilitation facility following hospitalization for a major medical illness
- You are unexpectedly admitted to a skilled nursing facility for a subacute rehab program following hospitalization for a major medical illness - this does not apply to those residing in a facility for long term care
- You are arrested, incarcerated, imprisoned, or otherwise forced into the custody of the legal system
- You do not speak English as a first language and were unable to secure a translator
- You depend on specialized transportation for the elderly and disabled (such as Abby Van) and we are able to confirm with the transportation company that they failed to transport you in a timely manner.
- The government issues a “shelter in place” order

✳ **Category B: acceptable reasons for missing your appointment with less than 24 hours notice or showing up between 15-30 minutes late**

- Your vehicle breaks down en route to your appointment, are able to confirm this with pictures, and call the clinic before your appointment to notify us of your circumstance
- You depend on public transportation and call the clinic before your appointment to notify us of your circumstance

- You depend on a caregiver to transport you to the clinic and your caregiver did not show up in time to get you to your appointment and you called the clinic before your appointment to notify us of your circumstance
- Your appointment is on a Monday and a message or voicemail was left more than 24 hours before your appointment notifying us of your need to cancel or reschedule your appointment
- You or your spouse is in active labor and you are able to provide documentation of labor and delivery records upon request
- In context of your distance from the clinic and the nature of the weather conditions, one of the following weather conditions occurs between your home and the clinic, confirmed by the national weather service: blizzard warning, ice storm warning, tornado warning, severe thunderstorm warning, flash flood warning, and you called the clinic to notify us of your safety concern
- You unexpectedly had to pick up your infant, toddler, or child from daycare or school due to either illness or behavioral issues, and are able to provide us with a letter from the school proving this to be true
- You got into a car accident on your way to your appointment and are able to provide documentation from a police report
- You were pulled over by the police for a traffic violation and are able to provide documentation proving this to be true (such as a ticket)

✳ **Category C: a no-show fee will be applied if the above criteria are not met. Examples of reasons for missing your appointment that will result in a no-show fee of $100.**

- You don't understand or remember why you had an appointment
- Your condition has improved or resolved
- You are too afraid, anxious, or depressed to come to your appointment
- You are in too much pain to come to your appointment
- You forgot about your appointment
- Weather conditions that do not meet the criteria in category B

II understand that Spears Pain & Rehab does not overbook patients and my appointment time is set aside specifically for me. Thus Spears Pain & Rehab reserves the right to charge a fee of $100.00 for each scheduled appointment that is cancelled with less than 24 hours notice, as

well as for no-shows. I also understand that I may be discharged from the care of Spears Pain & Rehab if I have more than 2 no-shows within any 6 month period.

I also understand that I will not be seen until any outstanding cancellation/no-show fees have been paid in full and that any self-pay fees are non-refundable.

Although the following scenarios are not foreseen to be apart of your care at Spears Pain & Rehab, it is your right to know that you are protected from balance billing for:

1. Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

2. Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact: https://www.cms.gov/nosurprises/consumers

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

This policy was last updated on September 30th, 2024 to version 1.2. If you were seen prior to September 30th, 2024, vision 1.1 of this policy applies. If you are being seen on or after September 30th, 2024, this policy is currently in effect and applies to your medical care.

Spears Pain & Rehab, S.C.

Dr Eric Spears, D.O., owner and president