Belmar Therapy

Phone 505.397.8023
Fax 505.808.4979
Email info@belmartherapy.com

Out-of-Network Consent & Estimated Costs

You're getting this notice because Belmar Therapy is not in your health insurance plan's network. This means we do not have an agreement with your insurance plan.

The purpose of this document is to…

1. Let you know about your protections from unexpected medical bills.
2. Ask if you would like to give up those protections and pay more for out-of-network care.
3. Provide you a good faith estimate about the cost of care.

I**MPORTANT: You aren't required to sign this form. 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.**

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.

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How do I learn more?

►**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 Belmar Therapy at 505.397.8023 or email info@belmartherapy.com

►**Questions about your rights?** Contact the New Mexico Human Services Department or the New Mexico Department of Health.

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.

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Our Best Estimate of Costs

Provider: Michael Campbell, M.S., CCC-SLP	
Location: 4004 Carlisle Blvd NE, St R5, Albuquerque, NM 87104 OR telehealth	
NPI #:	
Tax ID:	
NM State License #:	

Patient First Name:	**Patient Last Name:**	**Patient Date of Birth:**
Description of Services to Be Provided	**Evaluation:** We will assess and evaluate the patient's speech and language abilities. This includes things like how easy it is for other people to understand their speech; their ability to comprehend things that are said to them; and their ability to express themselves. We will write a report with details on our findings. Common CPT codes include but are not limited to: 92521, 92522, 92523, 96111	
	Speech &/or Language Therapy: This is skilled therapy of communication disorders with a licensed therapist. This typically occurs 1-3 times per week. Common CPT codes include but are not limited to: 92507, 92508, 97110, 97535, 97129	
Cost of Services at Belmar Therapy:	**Evaluation:** $225	
	Therapy: • 1, 30minute session - $45 • 1, 45minute session - $67.50 • 1, 60minute session - $90	

Depending on diagnosis and response to treatment, you may need between XX and XXX speech-language therapy sessions of 30 minutes each this year. Including 1 evaluation, at $45/session the estimated total costs are between $XXX and $XXX per year.

Please note: This is *only an estimate*. Additional services may be recommended at additional cost, and estimates will be provided. This is not an agreement to provide services.

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

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 Belmar Therapy 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.

_____ or _____

Patient's signature

Guardian/authorized representative's signature

_____

Print name of patient

_____

Print name of guardian/authorized representative

_____

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.