1/1/2022

To our patients:

The following form is being provided in compliance with the No Surprises Act for our patients who are out-of-network, electing not to use insurance, and/ or paying cash. Our 2022 rates for medical services are fixed at 195% of Medicare NY zone 02 rates. All balances for self-pay, out-of-network, and non-insurance visits are due at the time of service. The estimated prices provided reflect a self-pay discount on our rates to reflect decreased transactional costs when patients pay in full at time of service. Should payment in full not be rendered at time of service (in violation of our policy), our rates for medical services revert to 195% of Medicare NY zone 02 rates for billing and collection proceedings.

Sincerely,
The Billing Team at Halsey Dermatology

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 next page for your cost estimate.

Estimate of what you could pay

Patient name:_____

Out-of-network provider(s) or facility name: Halsey Dermatology

_____

Total cost estimate of what you may be asked to pay:	1st visit: $210-$3390 Follow up visits: $160-$3340

► **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 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 (631) 731-1099 and ask to speak with a medical assistant.

► **Questions about your rights?** Contact [*contact information for appropriate federal or state agency]*

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.

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

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

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

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☒ *Mark Halsey, MD*

☒ *Ashton Wilson, PA-C*

☒ Halsey Dermatology

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 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.
- 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.

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: Halsey Dermatology

_____

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.

Date of service	Service code	Description	Estimated amount to be billed
2022	99202, 99203 or 99204 99212, 99213, or 99214	New patient (1st) visit or Follow up visit	$210 (new) / $160(f/u)
2022	17110 or 17111	Destruction of benign lesions (on medical basis <15 or >=15)	$150 or $210
2022	17000,17003/17004	Destruction of pre-cancerous lesions (1st lesion, 2nd-19th or 20+)	$90 + $10ea add'l or $210
2022	11102, 11103	Skin biopsy (shave method,1st, each add'l)	$150 + $90 ea add'l
2022	11104, 11105	Skin biopsy (punch method,1st, each add'l)	$180 + $90 ea add'l
2022	11900, 11901	Intralesional injections (<7 or >=7)	$90 or $120
2022	N/A (cosmetic)	Cosmetic destruction with liquid nitrogen (skin tags, benign keratoses)	$85 + $45 ea add'l
2022	N/A (cosmetic)	Cosmetic treatment with laser (benign angioma or lentigo per lesion)	$225 + $125 ea add'l
2022	N/A (cosmetic)	Cosmetic Xeomin, Botox, Dysport or Jeuveau (one, two or three zones)	$450, $750 or $950, minus $50 if Xeomin
2022	N/A (cosmetic)	Cosmetic HA filler (Restylane, Belotero, Juvederm, or RHA, per 1mL syringe)	$700 per syringe
		Total estimate of what you may owe:	1st visit $210 - $3390 Follow up $160-$3340