Estimate of what you could pay

To be used for self-pay, uninsured or out-of-network patients

Patient name: _____

Provider(s) or facility name: KINEX PODIATRY _____

_____

Total cost estimate of what you may be asked to pay:	

► **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

► **If applicable, call your health plan.** Your plan may have better information about how much you will be asked topay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call [*Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]*

► **Questions about your rights?** https://www.cms.gov/nosurprises.

Prior authorization or other care management limitations

[*Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

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.]

[*In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]*

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):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

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 [*enter date of 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. 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: _____

Provider(s) or facility name: KINEX PODIATRY

_____

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.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.*].

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.*]

Date of service	Service code	Description	Estimated amount to be billed
TBD	99203	NEW PATIENT INITIAL EVALUATION	$140
TBD	99213/99214	ESTABLISHED PATIENT FOLLOWUP	$100
TBD	REFILL	RX REFILL CALL IN/PICKUP	$25
TBD	FORMS	ADMINISTRATIVE CHARGES FOR FORMS, FMLA, LETTERS ETC.	$100
TBD	MED REC	MEDICAL RECORDS UPTO 10 PAGES	$50 AND 0.05 EVERY PAGE AFTER THAT.
TBD	NS/LC	NO SHOW/ LATE CANCELLATION	$25
TBD	ORT	INSERTS	$55
TBD	X-RAY	X-RAY 2 VIEW X-RAY 3 VIEW	$60 $75
TBD	INJ	INJECTION	$150
TBD	INGR	INGROWN TOENAIL ADDITIONAL INGROWN NAIL	$150 $60
		Total estimate of what you may owe:	

**PRICES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE. PLEASE INQUIRE AT OFFICE FOR UPDATES AND OTHER PROCDURE CHARGES AS WELL AS PRICES OF THE PRODUCTS AVAILABLE FOR SALE.