



catalyst

Therapy and Sports Rehab

Would you like a Cost Estimate?

At Catalyst Therapy and Sports Rehab LLC, we believe in cost transparency and your right to shop for high quality, cost-effective services. We will be happy to provide you with a “Good Faith Estimate” of our costs upon request or upon scheduling. Call our office for more information or obtain our fee schedule. OR If you do not have health insurance or plan to self-pay for our services, we will provide you with a “Good Faith Estimate” of our costs when you schedule at least 3 days in advance. If you would like to request a Good Faith Estimate before scheduling, please call our office 620-282-4825 or email us at info@catalysttherapyks.com

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Your Right to Receive a Good Faith Estimate of Expected Charges under the No Surprises Act

Catalyst Therapy and Sports Rehab LLC will provide a “Good Faith Estimate” (“GFE”) of how much our services will likely cost you upon request. If you are paying us directly for your services and you schedule at least 3 days in advance, we will provide a written GFE within 1 day of scheduling. If you schedule at least 10 days in advance, we will provide a written GFE within 3 business days after scheduling. We will inform you in advance with a new GFE if we plan to increase our fees or we anticipate your costs exceeding your original GFE. If we don’t and we bill you more than \$400 in excess of your GFE without informing you in advance, you will have a right to dispute our bill through a federal dispute resolution process. You will need to provide a copy of your GFE to open a dispute, so we recommend that you save and/or print your GFE for future reference. To request a GFE, please contact us at info@catalysttherapyks.com or 620-282-4825. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1- 800-985-3059

 catalyst Therapy and Sports Rehab	Catalyst Therapy and Sports Rehab LLC
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	www.catalysttherapyks.com

NOTICE: “Right to Receive a Good Faith Estimate of Expected Charges” Under the No Surprises Act

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 620-282-4825.

Your Rights and Protections Against Surprise Medical Bills

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.

What is “balance billing” (sometimes called “surprise billing”)?

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.

You are protected from balance billing for:

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 balance billed for these post-stabilization services.

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.

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 the Department of Health and Human Services at 1-800-985-3059.

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