Self-Pay Policy for Office Visits

Nephrology and Hypertension Medical Associates understands not everyone has medical insurance or may want to avoid using their medical insurance. To help provide the care you need, we have implemented a discounted rate policy.

To obtain a full discounted payment, the payments listed below will need to be made prior to being seen

- For patients seen within the last 3 years, an established patient, the discounted rate would be $190.00 including any additional services; or,
- For patients that are being seen by our providers for the first time, New Patient, the discounted rate would be $240.00 including any additional services.

For those that are still unable to pay the full discounted amount upfront need to comply with the following:

- A minimum of $75.00 is placed as a down payment and you will be responsible for the full charge amount with no discount. This discount does not cover any other services that may be done during the visit, such as laboratory procedures, but these will be billed to the patient.
    a. For patients seen within the last 3 years, an established patient, the full charge can be up to $401.00 not including any additional services; or,
    b. For patients that are being seen by our providers for the first time, New Patient, the full charge can be up to $618.00 not including any additional services.

We hope our Self-Pay Policy for Office Visits helps you understand the discounts that are available if paid in advance of being seen. Please feel free to call our billing office at (912)354-4813 if you have any questions.

_____ (Initial) I request that NHMA NOT to file the insurance that is presently on file and will follow the self-pay policy noted above.

_____ (Initial) I do not have insurance and will follow the self-pay policy noted above.

_____ _____

SIGNATURE Date

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 balanced billed for these post-stabilization services.

The states of Georgia, South Carolina, and the federal government all have laws to protect you from balance billing, though they are different. State rules apply only to fully insured commercial health insurance plans and some government plans. Federal rules may also apply to commercial health insurance in situations where you received healthcare services in another state, your health insurance is regulated by a state other than Georgia or the healthcare service you received is not regulated by the state law. Most of the differences between the state and
federal laws are in the way the rules affect providers and health insurers, so you usually won't need to worry about that. However, the grievance processes are different, as indicated on the government websites listed below.

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. Under Georgia law, this rule also applies to

imaging centers, birthing centers and similar facilities, in addition to hospitals and ambulatory surgical centers. If you get other services at these in-network facilities, out-of-network providers cannot 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.

The best way to find an in-network provider is to use the online provider directory on your health plan's website.

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.

For Georgia, if you believe you've been wrongly billed, first contact your provider and/or your health plan for an explanation. If they can't resolve your concerns, you can contact the Georgia Office of the Commissioner of Insurance and Safety Fire online at https://oci.georgia.gov/ or by phone at 404-656-2070.
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.
Visit https://oci.georgia.gov/how-do-i-file-complaint for more information about your rights under Georgia law.

For South Carolina, if you believe you've been wrongly billed, first contact your provider and/or your health plan for an explanation. If they can't resolve your concerns, you can contact the Office of Consumer Services online at https://doi.sc.gov/1001/No-Surprises-Act-Information or by phone at 803-737-6160
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.
Visit https://doi.sc.gov/1001/No-Surprises-Act-Information for more information about your rights under South Carolina law.