# 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:** **DR. MOHAMMAD S. A. KHAN, M.D;/ ADULT CHILD & ADOLESCENT PSYCHIATRIC SERVICES, (ACAPS)**

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

**Review your detailed estimate.** See Page 3 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 to pay. You also can ask about what's covered under your plan and your provider options.

► **Questions about this notice and estimate?** Call 469-747-1010

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

**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):

☐ Mohammad Sarfaraz A Khan, MD

☐ Nurse P*ractitioner*

☐ ACAPS

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:** **MOHAMMAD S A KHAN M.D; /ADULT CHILD AND ADOLESCENT PSYCHIATRIC SERVICES, (ACAPS)**

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.**

**As courtesy to the provider's time and service and for potential new patient and follow up patients from losing an opportunity to schedule an appointment with the provider, all new patients must provide credit card to reserve their appointment time. In case New Patient fails to keep their appointment, their credit card charges will go towards late cancellation /No show. If the patient keeps the appointment these charges will be adjusted towards their visit charges or insurance remittance.

| Date of service | Service code | Description | Estimated amount to be billed |
|---|---|---|---|
| TBD | 90792 | NEW PATIENT INITIAL EVALUATION | $350 |
| TBD | 99214 | ESTABLISHED PATIENT FOLLOW-UP | $175 |
| TBD | UDS | URINE DRUG SCREENING | $40 |
| TBD | ADHD TEST | COMPUTERISED ADHD TESTING WITH UDS | $390 |
| TBD | ADHD TEST | COMPUTERISED ADHD TESTING WITHOUT UDS | $350 |
| TBD | REFILL | REFILL REQUEST CALL IN OR PICK UP | $25 |
| TBD | NS/LC | NO SHOW/ LATE CANCELLATION | $75 |
| TBD | FORM | LETTERS, FMLA, JURY ETC. ADMINISTRATIVE CHARGES | $100 |
| TBD | CRT AP | COURT APPEARANCE DUE BEFORE SERVICE | $400/HR |
| TBD | CRT DA | COURT DAY DUE BEFORE SERVICE | $3500 |
| TBD | APT CHARGE | APPOINTMENT RESERVATION CHARGE | $100 |
| | | **Total estimate of what you may owe:** | |

**PRICES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE. PLEASE CHECK WITH OFFICE BEFORE SERVICE.