

IMPORTANT FINANCIAL INFORMATION

Patient Name: _____

Appointment Date: _____

Notice of Hospital Outpatient Facility Fee and Billing Disclosure

- A. Your appointment with the Adult Outpatient Psych will take place in a hospital outpatient department of Sinai Hospital of Baltimore, Inc.
- B. Sinai Hospital of Baltimore, Inc. will charge a hospital outpatient department facility fee that is separate from and in addition to the bill you will receive from your provider
- C. You will receive two bills for your visit:
 - a. A provider services bill from your provider; AND
 - b. A hospital outpatient department facility fee bill from Sinai Hospital of Baltimore, Inc.

Expected fee:

Sinai Hospital of Baltimore, Inc. hospital outpatient department facility fee ranges are:

Services	Min Charge	Max Charge	Average Charge
Psych-Psychthrrpy 16-37Mins	\$ 476	\$ 532	\$ 505
Psych-Psychthrrpy 38-52Mins	\$ 571	\$ 639	\$ 607
Psych-Psychthrrpy 53-67Mins	\$ 857	\$ 958	\$ 908
Psych-Psychthrrpy	\$ 476	\$ 958	\$ 776
Family Psychotherapy W/ Patient 50 Mins	\$ 413	\$ 413	\$ 413
Adult Service Group Therapy	\$ 198	\$ 207	\$ 204
Psych-Adult Service Psych Eval	\$ 1,143	\$ 1,240	\$ 1,220

The hospital outpatient department facility fee could be higher if you require services during your appointment that we cannot reasonably predict today.

Financial help for your portion of the hospital outpatient department facility fee bill may be available. If you need financial help with the hospital outpatient facility fee bill, please contact

Customer Service at (800) 788-6995 or download the application on our website -

<https://www.lifebridgehealth.org/financialassistance>.

Receiving services in the hospital outpatient department may result in greater financial liability than receiving the services at a location where a hospital outpatient facility fee may not be charged.

No Hospital Outpatient Facility Fee Location:

Your provider does not see patients at another location within LifeBridge Health that does not have hospital outpatient facility fees.

INSURANCE INFORMATION:

Health Insurance and Medicare:

1. The amount of the hospital outpatient department facility fee that you will be responsible for paying will depend on your health insurance or Medicare coverage¹.
2. Health insurance companies could impose deductibles or higher copayment or coinsurance amounts for services provided in hospital outpatient departments.
3. If you have health insurance, you should contact your health insurance company to determine your health insurance coverage and your estimated financial responsibility for the hospital outpatient department facility fee, including copayments, coinsurance, and deductible amounts for the outpatient facility fee.

FACILITY FEE COMPLAINTS

If you have a complaint about an outpatient department facility fee charge, please contact Customer Service at (800) 788-6995.

If the complaint is unresolved, you may then file the complaint with the Health Services Cost Review Commission hscrc.patient-complaints@maryland.gov.

If you need additional information regarding your facility fee charges or if you need assistance mediating a facility fee complaint against a hospital, contact the Health Education and Advocacy Unit of the Office of the Attorney General 1-877-261-8807, HEAU@oag.state.md.us; www.MarylandCares.org

¹ Medicaid (primary and secondary) and Medicaid Managed Care Organizations (MCOs) only will not have a balance due.

ACKNOWLEDGEMENT

1. I understand that I will be billed a hospital outpatient department facility fee.
2. Sinai Hospital of Baltimore, Inc. provided me with information on the hospital outpatient department facility fees that will be billed for my appointment.
3. I understand that the fee could vary based on conditions and services provided to me that the hospital cannot reasonably predict today.
4. I understand that my out-of-pocket costs will depend on my health insurance or Medicare coverage.

____ (initial here) - By initialing here, I confirm that I received the facility fee information at the time I made my appointment with Adult Outpatient Psych.

By signing this form, I acknowledge that I have received the hospital outpatient facility fee information before receiving services today.

Signature (Patient)

Date

Signature (Patient Representative)

Date

To request this notice in an alternative format, please call customer service at (800) 788-6995 or E-Mail at CustomerServicesinai1@lifebridgehealth.org

Para solicitar este aviso en un formato alterno, por favor llame a 800-788-6995.