Spring Valley Pediatrics Consent and Good Faith Estimate Notice

Effective January 2022, the No Surprises Act requires health care providers that provide out-of-network care at in-network facilities to provide a good faith estimate of the out-of-network bill, options for in-network care, and a consent for patients/parents to sign who opt to receive out-of-network care at in-network facilities. When our pediatricians at Spring Valley Pediatrics perform hospital visits for newborns at Sibley hospital, we are providing out-of-network care at an in-network facility.

Patient name: _____

Patient date of birth/due date: _____

Out-of-network provider: Spring Valley Pediatrics, PLLC (tax ID:53-0224276), and its doctors.

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 will get.
►**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 is covered under your plan and your provider options.
►**Questions about this notice and estimate?** Call our Billing Office at (202) 966-1157
►**Questions about your rights?** Contact CMS, Centers for Medicare, and Medicaid Services, https://www.cms.gov/nosurprises or the Office of the Attorney General for the District of Columbia, OAG's Office of Consumer Protection at (202) 442-9828, consumer.protection@dc.gov for more information about your rights under federal law.

Prior authorization or other care management limitations
Spring Valley Pediatrics is an out-of-network provider. We do not participate with insurance companies. Payment is due at the time of service. After payment and as a courtesy for our patients, our billing office may submit the bill for medical services to insurance companies on behalf of patients. We indicate to insurance companies that reimbursement from insurance companies should be made directly to patients. You may receive a check from your insurance company based on your individual plan for out-of-network reimbursement. Because we are an out-of-network facility, no prior authorization is required for our services.

FRANCIS M. PALUMBO, MD CAROLINE VAN VLECK, MD JOANNA M. SEXTER, MD
PETER I. WARFIELD, MD JESSICA M. LONG, MD TARA MAMDOUHI, MD
4850 Massachusetts Avenue, NW, 2nd Floor
Washington, DC 20016
202-966-5000
FAX 202-966-3830

Understanding your options
You can also get the items or services described in this notice from providers who are in-network with your health plan: A hospitalist pediatrician at Sibley Memorial Hospital is available to see your newborn.

More information about your rights and protections:
Contact CMS, Centers for Medicare and Medicaid Services, https://www.cms.gov/nosurprises or the Office of the Attorney General for the District of Columbia, OAG's Office of Consumer Protection at (202) 442-9828, consumer.protection@dc.gov, 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):

☐ **Dr. Francis Palumbo (NPI: 1043340888) , Dr. Caroline Van Vleck (NPI: 1386775690), Dr. Joanna Sexter (NPI:1568514123), Dr. Peter Warfield (NPI: 1225116502), Dr. Jessica Long (NPI: 1942525324), Dr. Tara Mamdouhi (NPI: 1770044125)**

☐ **Spring Valley Pediatrics, PLLC**

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 am giving up some consumer billing protections under federal law.
- I will get a bill for the full charges for these items and services and may not receive reimbursement for these charges under my health plan.
- I was given a written notice on _____/_____/_____ explaining that my provider is not 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.
- 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 am not obligated to receive the services described in this notice and can end this agreement by notifying the provider in writing before getting services.

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IMPORTANT: You do not have to sign this form. But if you do not 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 representative | Print name of guardian/authorized

_____ _____

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.

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More details about your estimate

Patient name: _____

Out-of-network provider(s)or facility name: **Spring Valley Pediatrics, PLLC, and its doctors.**

The amount below is only an estimate; it is not an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It does not include any information about what amount, if any your health plan may provide you as reimbursement for these charges. **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 may provide to you as reimbursement for these charges.
Every newborn seen by Spring Valley Pediatrics will receive one or two hospital visits for newborn examinations. The pediatricians at Spring Valley Pediatrics will determine whether one or two visits are indicated based upon the type of delivery, the length of stay, and what is deemed medically necessary by the provider.

Date of service	Service code amount to be billed	Description	Estimated
TBD	CPT: 99460	Admission	$389
TBD	CPT: 99238	Discharge	$335
TBD	CPT: 99468	Admit/Discharge	$506

Total estimate of what you may owe for hospital visits: $506-$724

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