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What you could pay Good Faith Estimate

Patient name:Click or tap here to enter text.

Out-of-network provider(s)or facility name: Click or tap here to enter text.

Sophia Center Click or tap here to enter text.

Total cost estimate of what you may be asked to pay: Click or tap here to enter text.

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 Sophia Center. 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 Click or tap here to enter text. 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. You can choose to get care from a provider or facility in your health plan’s network.

Patient’s signature: Click or tap here to enter text.

Guardian/authorized representative’s signature: Click or tap here to enter text.

Print name of patient: Click or tap here to enter text.

Date and time of signature: Click or tap here to enter text.

Print name of guardian/authorized representative: Click or tap here to enter text.

Date and time of signature: Click or tap here to enter text.