



HB 2041 DISCLOSURE

Fairfield Emergency Room is an out-of-network provider for all health benefit plans.

Fairfield Emergency Room will work with your insurer to file a claim on your behalf and use all reasonable and lawful efforts to ensure your insurer reimburses at the highest level of benefits in accordance with state and federal law and your specific benefit plan.

This facility charges a facility fee for medical treatment:

***The Median facility fee for [Fairfield ER] is \$5,273.58**

Level Of Care	Facility Fee
Emergency Dept Visit Level 1	\$500.00
Emergency Dept Visit Level 2	\$3,355.15
Emergency Dept Visit Level 3	\$4,525.65
Emergency Dept Visit Level 4	\$6,750.75
Emergency Dept Visit Level 5	\$9,575.50

Level Of Service	Range of Possible Fees
Emergency Dept Visit Level 1	Up To \$500
Emergency Dept Visit Level 2	\$3,355.15 To \$5,272.69
Emergency Dept Visit Level 3	\$4,525.65 To \$14,131.72
Emergency Dept Visit Level 4	\$6,750.75 To \$41,780.79
Emergency Dept Visit Level 5	\$9,575.50 To \$109,527.41

This facility charges an observation fee for medical treatment:

Observation Fees	
Median Observation Fee	\$6,750.75
Range of Observation Fees	\$2,500 To \$45,000
Observation Fee for Level of Service	\$2,500.00

Range of Observation	
Level Of Service	Range of Possible Fees
Emergency Dept Visit Level 1	-
Emergency Dept Visit Level 2	-
Emergency Dept Visit Level 3	-
Emergency Dept Visit Level 4	-
Emergency Dept Visit Level 5	\$12,075.5 To \$109,527.41

I acknowledge receiving a copy of this disclosure statement. For any further questions regarding this disclosure statement, you may contact the following:

**Fairfield Emergency Room
Caidin Pierce, Facility Administrator
15103 Mason Rd Suite E-1
Cypress, TX 77433
832-6197937**

Patient/Legal Representative
Name: _____

Date: _____

Patient /Legal Representative
Signature: _____

Date: _____

Witness
Name: _____

Date: _____

Witness
Signature: _____

Date: _____