Out-of-Network Consent and Financial Responsibility Form

Please read this document carefully. This form informs you about your financial responsibility when receiving healthcare services from a provider or facility that is not in your health insurance plan's network.

Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Provider and Facility Details

Out-of-Network Provider Name:

Facility/Practice Name:

Estimated Cost of Services

The service(s) listed below are being provided on an out-of-network basis.

Description of Services:

Estimated Total Charge:

Estimated Amount Covered by Insurance (if known):

Estimated Patient Out-of-Pocket Responsibility:

Financial Disclosure and Acknowledgments

By signing below, you acknowledge and agree to the following terms:

- You understand that the provider/facility named above does not participate in your health insurance plan's network.
- You understand that your health insurance plan may not cover the services provided, or may cover them at a significantly lower rate, leaving you with higher out-of-pocket costs.
- You understand that you have the right to seek care from an in-network provider to avoid these out-of-network charges.
- You accept full financial responsibility for all billed charges associated with these services, including any balance not paid by your health insurance provider.
- You agree to pay the provider/facility for all services rendered under this agreement.

Consent and Signature

I have read and fully understand this Out-of-Network Consent and Financial Responsibility form. I authorize the out-of-network provider to deliver the scheduled services, and I agree to pay all associated costs as outlined above.

Authorized Signature (Type Full Name):

Relationship to Patient (e.g., Self, Parent, Guardian):

Date Signed (MM/DD/YYYY):