FACILITY OUT-OF-NETWORK DISCLOSURE

_____ and _____
Patient Name Health Benefits Plan

- Endo Surgi Center, P.A. is out-of-network for the health benefits plan named above.
- The total amount you owe may be more than the copayment, deductible, and/or coinsurance amount required by your health benefits plan.
- You may be charged the difference between what your health benefits plan pays Endo Surgi Center, P.A. and what is Endo Surgi Center, P.A. charge for the services provided.
- You should contact the health care professional ordering the services to be provided in Endo Surgi Center, P.A. to determine if he or she is in-network or out-of-network for your health benefits plan.
- You should contact your health benefits plan for information regarding your copayment, deductible and/or coinsurance amount. Contact information is typically found on the card provided to you by your health benefits plan.
- In some cases, health care professionals other than the one ordering the service may provide and bill for care in this facility. You can expect for services to be provided by
  Physician Name: _____
  You can access information regarding the health benefits plans that these health care professionals participate in on Endo Surgi Center, P.A. website at endosurgicenter.com. If you do not have internet access, a copy of this information will be provided to you upon request by Endo Surgi Center, P.A..

I agree that I have read and understand this form and have been provided a copy of it.

_____ _____
Patient's Signature **Date**

ACKNOWLEDGEMENT OF SELECTION OF OUT-OF-NETWORK PROVIDER SERVICES

_____ **and** _____
Patient Name **Health Benefits Plan**

I, _____, specifically request the services of the following health care provider, _____, whom I have been advised does not participate in and is "out-of-network" with my health benefits plan.

I understand that I may owe more than the copayment, deductible, and/or coinsurance amount of my health benefits plan.

I further understand that I may be charged the difference between what my health benefits plan pays _____ and what is *the* _____ charge
Physician Name **Physician Name**
for the services provided.

_____ _____
Patient's Signature **Date**