**DISCLAIMER**

 T

he New Jersey Hospital Association’s (NJHA) Out-of-Network Implementation Toolkit (hereinafter “materials”) are intended to be tools that hospitals may use to implement and comply with the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.” The information provided in these materials should not be relied upon or regarded as legal advice. No specific representation is made, nor should be implied, nor shall NJHA or any other party involved in creating, producing or delivering this material be liable in any manner whatsoever for any direct, incidental, consequential, indirect or punitive damages arising out of your use of these materials. NJHA makes no warranties or representations, express or implied, as to the accuracy or completeness of the information contained or referenced herein. This publication is provided “AS IS” WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESSED OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR NON-INFRINGEMENT. Some jurisdictions do not allow the exclusion of implied warranties, so the above exclusion may not apply to you. All images and information contained in these materials are copyrighted and otherwise proprietary. No use of this information is permitted without the prior written consent of NJHA. If you have other questions or concerns, please contact NJHA’s Legal Affairs at 609.275.4089.

**ACKNOWLEDGEMENT OF REQUEST
FOR OUT-OF-NETWORK PROVIDER SERVICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been informed that this facility is **out-of-network** with my health insurance plan and further:

* My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan;
* I may be responsible for any excess amount above the allowed amount the health insurance plan pays or reimburses the provider for healthcare services I received; and
* I should contact my health insurance plan to identify the specific potential costs for which I am/may be responsible.

I acknowledge that I am **knowingly and voluntarily** accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.

**Print Name**

****

**Signature Date**