**DISCLAIMER**

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**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**

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**Signature Date**