Allied Digestive Health

NOTICE OF OUT-OF-NETWORK PROVIDER STATUS AND PATIENT AGREEMENT TO PAY

Date of Notice _____

Dear Patient:

You are being provided with this Notice of Out-of-Network Provider Status and Patient Acknowledgment and Agreement to Pay because we have determined that the health care provider from which you have requested services is not a participating provider with your insurance carrier health benefit plan.

Please be advised that your insurance carrier may deny payment, in whole or in part, for services performed by health care professionals deemed to be non-participating providers or "out-of-network" with your applicable health benefit plan. If you receive services performed by a health care professional who is not a participating provider under your applicable carrier health benefit plan, your insurance carrier may deny payment of, or refuse to authorize, that service. This means that you will have financial responsibility for any costs associated with services provided by an out-of-network professional, in excess of your copayment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plan.

The following is a list of providers from which you have requested services who are not participating providers under your health benefit plan, as well as the approximate cost you will be responsible for paying us in the event of a denial of payment by your insurance carrier:

Name of Out-of-Network Provider and Description of Services Likely to be Denied in Whole or in Part	**Approximate Patient Out-of-Pocket Costs**

If you have additional questions about why the above item or service may not be covered (in whole or in part), please contact your insurance carrier's customer support service at the number located on the back of your insurance card.

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Patient Acknowledgement and Agreement to Pay:

I have been notified by **Allied Digestive Health** that my insurance carrier may deny payment, in whole or in part, for the services, supplies and equipment identified above, as the health care professionals from whom I have requested services are not participating providers with my health benefits plan. I understand that I have the right to decide whether or not to receive the services identified above. **I have knowingly, voluntarily and specifically selected an out-of-network provider to provide services. If my insurance carrier refuses to authorize or denies payment for such services under my health benefit plan, I agree to be personally and fully responsible for payment to Allied Digestive Health** I understand and agree that I am obligated to pay this amount regardless of whatever amount appears as "member responsibility" on any Explanation of Benefits form I may receive from my insurance carrier. I agree to pay the foregoing amount before the service, supply or equipment are rendered.

Patient's Signature_____Date of Signature _____

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