

(Your Letterhead Here)

**OUT OF NETWORK
WAIVER FORM**

Date of Service: ____/____/____

HIC#: _____

Patient Name: _____

Physician Name: _____

Name of HMO, PPO, etc.: _____

Your signature below signifies that you clearly understand that

Dr. _____ is NOT a member of your managed care plan. Because the doctor is NOT on your plan, the expenses for today's visit will be *your* responsibility. This means you will have to pay the doctor's charges in full at the end of today's visit.

After you have paid for your visit today, the receptionist will provide you with a properly coded insurance form. Take this form and forward it to your managed care plan, keeping a copy for your records. Depending on the type of plan you have, you may be reimbursed only a percentage of the money you paid.

Know your plan benefits. Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

Do not sign this form unless you positively understand the financial responsibilities of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the nonparticipating/out-of-network physician today.

Signature of patient: _____ Date _____

Signature of witness: _____ Date _____