DISCLOSURE OF INSURANCE PLAN PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and the Board of Medical Examiners and/or New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Health Care Professional Participates With

Facilities Physician Is Associated with and Address:

If the patient's health plan is not listed above, the physician and/or facilities providing services does not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Licensed Assistant Healthcare Staff:

The following licensed healthcare professionals may perform assistant surgeon services on the patient based upon the treatment plan and needs of the patient:

Anesthesia, Radiology, Laboratory, Pathology Services:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures.

Patient should inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;
   Patient initials: _____

2) I understand that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

   Patient initials: _____

3) Upon receipt of a request from the patient for the service and the Current Procedural Terminology (CPT) codes associated with that service, the health care professional shall disclose to the patient in writing the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

   Patient initials: _____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by their health benefits plan; and

   Patient initials: _____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Patient initials: _____

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Signature: _____ Date: _____

Print Name: _____