AFFILIATED AMBULATORY SURGERY, PC
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ACKNOWLEDGEMENT OF SELECTION OF OUT-OF-NETWORK PROVIDER SERVICES

Patient Name: _____ Account #: _____

Date of Birth: _____ Health Plan: _____

I, _____, specifically request the services of the following health care provider, _____, who I have been advised does not participate in and is "out-of-network" with my health benefits plan.

I understand that I may owe more than the copayment, deductible, and/or coinsurance amount of my health benefits plan.

I further understand that I may be charged the difference between what my health benefit plan pays Dr. _____ and what is Dr. _____'s charge for the services provided.

I agree that I have read and understand this form and have been provided a copy of it.

Patient Signature: _____ Date:_____

Witness Signature: _____ Date:_____