

**By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.**

With my signature, I am saying that I agree to get the items or services from (select all that apply):

- [doctor's or provider's name] [if consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]
- [facility name]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

**IMPORTANT:** You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

\_\_\_\_\_  
Patient's signature

or

\_\_\_\_\_  
Guardian/authorized representative's signature

\_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.