advocare

CARE CENTER: _____

Professional/Provider Out of Network Disclosure Notification

Patient Name: _____

Account Number: _____

Primary Insurance Plan: _____

Healthcare Provider: _____

I have been notified that my healthcare professional is **Out of Network** (OON) with my health insurance plan.

I was also informed:

- ✓ My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan;
- ✓ I may be responsible for any excess costs above the allowed amount the health insurance plan pays or reimburses the provider for healthcare services I received; and
- ✓ I should contact my health insurance plan regarding any questions about potential costs.

Information on the insurance plans that Advocare physicians and providers participate with are on the website at https://www.advocaredoctors.com

I acknowledge that I am **knowingly and voluntarily** accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.

Patient Signature (or authorized representative)	Relationship (if not the patient)	Date