

SURGICAL CENTER AT MILLBURN

Network Disclosure Form

The Center Name

I, _____ have been informed that this facility is

- ☐ **In-Network** with my insurance plan
- ☐ **Out-of-Network** with my insurance plan and further, if I am out-of-network the following applies:
 - My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan;
 - I may be responsible for any excess amount above the allowed amount the health insurance pays or reimburses the provider for healthcare services I received; and

I am aware I should contact my health insurance plan to identify the specific potential costs for which I am/may be responsible.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any financial responsibility associated with healthcare services that I receive.

Signature of Patient/Legal Guardian

Patient Name (Please Print)

Witness Signature