California State Out-of-Network Consent

The purpose of this document is to inform you that we are out-of-network with your health plan and that you must consent to being billed more for this service.

You are receiving this disclosure form because you are scheduling a non-emergency procedure and this provider is not in your health plan's network. This means the provider does not have an agreement with your plan. Receiving services could cost you more.

You may choose to seek care from a provider that is in your health plan's network. You may also contact your health plan for help with finding an in-network provider who will provide the health service for a lower out-of-pocket cost.

Because this provider is out-of-network, you are being provided an estimate of the amount you will be billed by the provider. Please note that this is only an estimate and that the actual bill may differ. See page 2 for an estimate of what you will be charged.

The estimate will contain the amount or estimated amount that the provider will bill you for the service, and the Current Procedural Terminology (CPT) codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided.

By choosing to receive services from this provider, your financial responsibility will be:

1) More than if you receive services from an in-network provider and;
2) More than your in-network copayment, coinsurance, or deductible.

Please contact your health plan for further consultation about the costs associated with your out-of-network services.

With my signature, I acknowledge that I have read this consent form, understand its contents, and am consenting to being billed more than if the procedure was performed by an in-network provider. **I understand that I do not have to sign this form. But if I do not sign, this provider does not have to provide services to me.**

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

Details about your Estimate

Patient name: _____

Out-of-network provider(s): _____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may haveto pay.

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	