FIRSTChoice
NEUROLOGY
Florida's Largest Neurology Group

Out of Network Agreement

Form Date of Service: ________________

Patient Name: __________________________________

Date of Birth: _________________

Guarantor Name:________________________________

Physician Name:

Name of Insurance: ____

Your signature below signifies that you clearly understand that the provider mentioned above is NOT a member of your insurance plan.

Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. The estimate cost of today's visit will range from $_____to $______.

This means you will have to pay the doctor's charges in full at today's visit. Our office will NOT file a claim to your carrier.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

DO NOT sign this form unless you positively understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

Please understand that some plans will NOT approve medications or treatments as covered if order by a non-participating provider. This means services like your medication, EEG, MRI, or other medical services may not be covered even if order or perform in a network facility until a participating provider orders the services.

We are NOT your insurance plan so any questions you might have about your plans or benefits please contact your benefit administrator or your insurance plan directly.

I understand all of the above and still want to receive services from the non-participating physician today.

Signature of Patient/Guarantor: _____________________________ Date: ___________