FIRST Choice NEUROLOGY
Florida's Largest Neurology Group

Out of Network Agreement

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 out-of-pocket expenses for today's visit will be higher than if you went to an in-network provider. The estimate cost of today's visit will range from

$_____ to $_____. This depends on the benefits purchased by you from your insurance and we will know when the claim is adjudicated.

This means you will have to pay the estimated patient responsibility of $_____. Our office will file a claim to your carrier and will bill you for the rest or refund you if today payment is an overpayment.

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 the above and still want to receive services from the non-participating physician today.

Signature of Patient/Guarantor: _____Date: _____