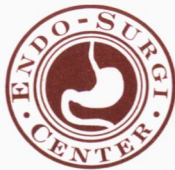




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ENDO-SURGICENTER

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Specialists in Outpatient Gastrointestinal Endoscopy, Pain Management and Surgery
"We are making quality a top Priority"

SELF-FUNDED PLAN OUT-OF-NETWORK DISCLOSURE

_____ and _____
Patient Name Self-Funded Plan

- Endo Surgi Center, P.A. is out-of-network for the self-funded plan named above.
 - The total amount you owe may be more than the copayment, deductible, and/or coinsurance amount required by your self-funded plan.
 - You may be charged the difference between what your self-funded plan pays Endo Surgi Center, P.A. and what is Endo Surgi Center, P.A. charge for the services provided.
 - You should contact your self-funded plan administrator for information regarding your copayment, deductible and/or coinsurance amount. Contact information is typically found on the card provided to you by your self-funded plan.
 - You should contact the health care professional ordering the services to determine if he or she is in-network or out-of-network for your self-funded plan.
 - You should contact your self-funded plan administrator for information regarding copayment whether they have opted into in-network coverage for out-of-network services provided inadvertently or in an emergency or on an urgent basis. Billing disputes with self-funded plans that have opted into in-network coverage for services rendered in an emergency or on an urgent basis may be resolved through arbitration. Contact information is typically found on the card provided to you by your self-funded plan.
 - In some cases, health care professionals other than the one ordering the service may provide and bill for care. You can expect for services to be provided by _____
Physician Name
- You can access information regarding the health benefits plans that these health care professionals participate in on Endo Surgi Center, P.A. website at endosurgicenter.com. Services may be provided on an out-of-network basis in regard to your self-funded plan. If you do not have internet access, a copy of this information shall be provided to you upon request by Endo Surgi Center, P.A..

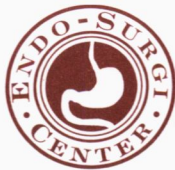
I agree that I have read and understand this form and have been provided a copy of it.

Patient's Signature

Date



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ACKNOWLEDGEMENT OF SELECTION OF OUT-OF-NETWORK PROVIDER SERVICES

_____ and _____
Patient Name Self-Funded Plan

I, _____, specifically request the services of the following health care provider, _____, whom I have been advised does not participate and is "out-of-network" with my self-funded plan.

I understand that I may owe more than the copayment, deductible, and/or coinsurance amount of my self-funded plan.

I further understand that I may be charged the difference between what my self-funded plan pays _____ and what is the _____ charge for the services provided.
Physician Name Physician Name

Patient's Signature

Date