University SurgiCenter

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ACKNOWLEDGMENT OF SELECTION OF OUT-OF-NETWORK PROVIDER SERVICES

Health Benefit Plan: _____

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

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

I further understand that I may be charged the difference between what my health benefits plan pays University SurgiCenter and what is University SurgiCenter's charge for the service provided.

Acknowledged and agreed to by:_____

Print name:_____ Date:_____