



Surprise Bill Consent

A surprise bill is when is when you received services from a non-participating physician and/or a non-participating hospital or ambulatory surgical center without your knowledge.

1. I understand that I may be responsible for additional costs for all services provided by the non-participating facility/provider
2. I was given an opportunity to seek care by an participating facility/provider
3. I understand that absent of special circumstances (e.g., financial hardship), the non-participating facility/provider is prohibited from waiving co-payments, deductibles, coinsurance or other member cost sharing amounts.
4. I am voluntarily choosing on behalf of myself or my child/legal guardian to obtain the service or procedure from the non-participating facility and/or physician

PATIENT NAME: _____

SIGNATURE: _____

Date: _____