DISCLOSURE OF INSURANCE PARTICIPATION STATUS

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Dr. Bazerbashi/Nurse Practitioner is **Out of Network** with Cigna, Aetna, United Healthcare, Horizon and ALL Blue Cross Blue Shield.

The following testing will be interpreted by **OUT OF NETWORK DOCTORS:**

***EKG, Spirometry, Stress ABI, Segmental ABI, Nerve Studies, Holter Monitors, Take Home Sleep Studies, Attended Sleep Studies, Ultrasounds, Echos, Vein Ultrasounds, CPETs.**

Any CPAP supplies are **OUT OF NETWORK.**

The following services offered at Medical Art Center are **OUT OF NETWORK** with Horizon:

***Chiropractor, Acupuncture, Pain Management**

BLOOD WORK, SWABS, AND OTHER TESTING PERFORMED AT OUR OFFICE WILL BE SENT TO **OUT OF NETWORK** LABORATORIES.

The patient is hereby notified and understands that these services may not participate with the patient's health insurance plan and may be "out of network providers" subject to the following disclosures. Patient may contact their health plan or administrator for further consultation on costs associated with these services.

Mandatory Disclosures:

Patient Initials : _____ I understand that Medical Art Center has health care professionals that are "out of network" with and does not participate with my health insurance plan.

Patient Initials : _____ I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request:

Patient Initials: _____ I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service.

Patient Initials : _____ I understand that I will have a financial responsibility applicable to health care services provided by an out of network professional, in excess of my in network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Patient Initials : _____ I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs:

Acknowledgment of Receipt of Disclosures- OUT OF NETWORK PATIENTS

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternate health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do upon my own free will.

Signature: _____

Print Name: _____

Date: _____