HOPE419

Out-of-Network Provider Agreement Form

By signing below, I acknowledge the following:

1. I am aware that the health care providers and facility at Hope419 will be involved in my care and I understand that these health care providers and facility are not participating providers in the ___________________________ network.
2. I declined the opportunity to select a participating provider to provide my mental health services and I am voluntarily choosing to obtain services from a non-participating provider.
3. I am aware that I may be responsible for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan.
4. I understand that non-participating providers are generally prohibited from waiving member cost share amounts such as copayments, deductibles, and coinsurance.
5. I understand that this means that the services provided to me may not be covered by my insurance, may be covered at a higher rate than an in-network provider, may require a higher copay or coinsurance, or may be applied to an out-of-network deductible, and I am responsible for knowing my out-of-network benefits.
6. I further understand that I am responsible for the full amount of each visit regardless of the amount my insurance company does or does not pay.
7. I understand that Hope419 is not under any obligation to obtain authorizations for services provided to me as a non-participating provider.

Printed Patient Name: ____

Signature of Responsible Party: ___________________________________ (Patient, Parent or Legal Guardian - if patient is under age 18)