Out of Network Waiver Form

Date of Service: _____

Patient Name: _____ Date of Birth: _____

Physician Name: Cynthia Rogers, M.D.

Name of Insurance: _____

Your signature below signifies that you clearly understand that

Dr. Cynthia Rogers is NOT a member of your managed care plan. Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. This means you will have to pay the doctor's charges in full at the end of today's visit.

Our office will file a claim to your carrier as a courtesy.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

Do not sign this form unless you positively understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating physician today.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____