CONSENT TO RECEIVE OUT OF NETWORK SERVICES

I understand that Dr. Sackheim is out of network with my insurance and that she accepts out of network benefits.

Dr. Sackheim's office will do an insurance benefit verification check as a courtesy and inform me of an estimated out of pocket responsibility before my scheduled appointment.

I will be responsible for payment on the date of service due to any out of network deductible or out of pocket maximum amount not met.

I give Spine & Pain Total Care, P.C. permission to bill my insurance for possible partial or full payment through my out of network benefits on my behalf. I understand that I may have a financial obligation in addition to any insurance payments.

I am aware that I **cannot** submit reimbursement claims to my insurance for payments made to Spine & Pain Total Care, P.C. unless I pay for the services rendered in full at the time of my appointment.

I understand that my financial cost share, or co-insurance/deductible, may be higher than with an in-network provider.

Spine & Pain Total Care develops rates and fees based on out of network amounts shown for zip code 10028 on www.fairhealthconsumer.org.

I HAVE READ AND UNDERSTAND THE ABOVE PROVIDED INFORMATION.

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PRINT NAME **SIGNATURE**

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DATE