

## Do you agree to pay more for out-of-network care and give up important legal protections?

This doctor or provider is not in your health plan's network. This means the doctor or provider does not have a contract with your plan.

### If the service or supply is medically needed:

- State law protects patients with some types of health plans from higher bills from out-of-network providers. If you sign this form, you lose the protection of the law.
- If you sign this form, you agree to pay up to the full billed charges for these services and supplies.
- Your health plan might not count the extra amount you pay toward your out-of-pocket limit.
- Before you sign this form, you can ask your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider or another provider.
- If you have a plan that is an HMO (health maintenance organization) or EPO (exclusive provider benefit plan), it may not pay anything for out-of-network services and supplies.
- You should **not** sign this form if you believe your case is an emergency.
- You should **not** sign this form if you did not have a choice of providers. For example, if a doctor was assigned to you.

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## Estimate of what you may pay

**Patient name:** \_\_\_\_\_

**Out-of-network doctor or provider name:** \_\_\_\_\_

The charges may change if the type or amount of services or supplies changes.

<b>Total estimate of what you may need to pay (insurance will not cover):</b>	
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- ▶ **Detailed estimate.** See Page 3 for the estimated charge for each service or supply you get.
- ▶ **Call your health plan.** Your plan may have better information about how much you may need to pay. You also can ask about your provider options.
- ▶ **Questions about your rights?** Call the Texas Department of Insurance at 1-800-252-3439 or go to [www.tdi.texas.gov](http://www.tdi.texas.gov).

## I agree to give up (waive) my rights for consumer protection

- I understand I am giving up some consumer protections under state law.
- I understand I may get a bill for up to the full billed charges for these services and supplies. (This is called balance billing.)
- I signed this form at least 10 business days before getting services or supplies.
- I understand I have 5 business days to cancel this agreement (see "Notice of my right to cancel" below). I also understand I can't cancel after I get the services or supplies listed on this form.
- I was able to get my questions answered before signing this form.

\_\_\_\_\_  
Patient's signature

or

\_\_\_\_\_  
Guardian or legal representative's signature

\_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Print the guardian or legal representative's name

**Keep a copy of this form. It contains important information about your rights.**

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## Notice of my right to cancel

You have 5 business days to cancel this agreement to give up (waive) your consumer protections.

### To cancel:

- You must notify the provider in writing at: \_\_\_\_\_  
\_\_\_\_\_
- You may sign below or use any written statement that is signed and dated and states that you want to cancel.
- You must send the notice to the provider on or before:\_\_\_\_\_.

### I wish to cancel this agreement

\_\_\_\_\_  
Patient's signature

or

\_\_\_\_\_  
Guardian or legal representative's signature

\_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Print the guardian or legal representative's name

**If you cancel, keep a copy of your notice and proof that you sent it.**

## More details about your estimate

Patient name: \_\_\_\_\_

Out-of-network doctor or provider name: \_\_\_\_\_

The charges may change if the type or amount of services or supplies changes.

Date of service	Service or supply – code and name	Amount to be billed	You may need to pay
<b>Total estimate of what you may need to pay (insurance will not cover):</b>			