Giliberti Eye
& LASER CENTER

Acknowledgement of Request for Out-of-Network Provider Services

I, _____ have been informed that this facility is **out-of-network** with my health insurance plan and further:

- My potential financial responsibility may exceed my copayment, deductible, or coinsurance with my health insurance plan;
- I may be responsible for any excess amount above the allowed amount the health insurance plan pays or reimburses the provider for healthcare services I received; and
- I should contact my health insurance plan to identify the specific potential costs for which I am/may be responsible.

I acknowledge that I am **knowingly and voluntarily** accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.

_____

Print Name

_____

Signature **Date**

Orazio L. Giliberti, M.D. F.A.C.S. ✷ **Dominick I. Golio, M.D.** ✷ **Francesca M. Giliberti, M.D., J.D.**
Eye Physician & Surgeon | Eye Physician & Oculoplastic Surgeon | Eye Physician & Surgeon

Totowa Professional Building ✷ 415 Totowa Road ✷ Totowa, New Jersey 07512
Phone: (973) 595 – 0011 ✷ Fax: (973) 595 – 5155
www.laserandeye.com