Mara C. Galvin, MD
Eugene H. VandenBoom, MD
Carla R. Pearman, MD
Cathanie W. Halberstadt, MD
Lisa L. Amsterdam, MD
Johanna G. Finkle, MD
Courtney A. Angell, MD
Crystal D. Taylor, DO
Mary E. Brulja, DO
Susan Ezell, DO

Rockhill Women's Care

WAIVER AND ACKNOWLEDGEMENT OF

OUT OF NETWORK SERVICES

I,

_____
(Patient's First, Middle and Last Name)

Hereby acknowledge that I understand Rockhill Women's Care, Inc. and

_____
(Name of Provider)

Are not contracted with my Insurance Carrier,

_____
(Name of Insurance Company)

I understand that by utilizing Rockhill Women's Care, Inc. and

_____
(Name of Provider)

Instead of an In-Network or Contracted Provider, my insurance benefit level will be reduced or completely void and will therefore increase my personal financial responsibility.

I am voluntarily making this decision and I agree to accept the reduced benefits and increased personal financial responsibility.

_____
(Patient's First, Middle and Last Name)

_____
(Patient's Date of Birth)

_____
(Patient's Signature and Date)