Rockhill Women's Care

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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)