TDI | Texas Department of Insurance

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.

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.

Total estimate of what you may need to pay (insurance will not cover):	

► **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.

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.

_____ or _____

Patient's signature | 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.

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

_____ or _____

Patient's signature | 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
Total estimate of what you may need to pay (insurance will not cover):			