

Pascack Valley Medical Center 7600 River Rd, North Bergen, NJ 07047 Billing & Insurance 866-525-5557

Effective: 09/01/2018

ACKNOWLEDGEMENT OF REQUEST FOR OUT-OF-NETWORK PROVIDER SERVICES

Patient Name: _____ HAR #: _____

Reg. Date/Time:	MR #:
I,named above is outofnetwork with my h	
✓ My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan.	
	cess amount above the allowed amount reimburses the provider for healthcare
✓ I should contact my health insurar potential costs for which I am/may	, ,
I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.	
Patient Name (Print)	Patient Signature
Date signed:	_
Witness's Name (Print)	Witness's Signature
Date signed:	_