Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

OUT OF NETWORK DISCLOSURE LAW

I, _____ , understand that **Dr. Stephen Harris is NOT participating with my insurance company**; therefore, any medical service provided will be processed toward my *out-of-network benefits*.

I understand that Dr. Harris has agreed to accept the "AMOUNT ALLOWED" by my insurance company, which, in most cases, represents a discount of his customary fee. I undertand the "ALLOWED AMOUNT" is the dollar value *my insurance company dictates* as the usual and customary amount for the service performed. I understand the "PAYMENT AMOUNT" is the dollar value actually paid by *my insurance company.*

I understand that any "PAYMENT AMOUNT" paid by *my insurance company* may not satisfy the "ALLOWED AMOUNT", and **I, therefore, agree to pay any balance due up to the "ALLOWED AMOUNT"**. This difference between the "ALLOWED AMOUNT" and the "PAYMENT AMOUNT" is made up of the amount applied to the *deductible and coinsurance*.

I understand, that upon request, the amount or estimated amount for non-emergency services will be provided.

I understand that I may receive payment and/or correspondence from my insurance company and agree to remit any payment and/or correspondence to Dr. Harris immediately upon receipt. I understand that I will receive a bill from Practice Management Advisors, the billing service for Harris Plastic Surgery, reflecting any outstanding unpaid balances.

I understand that Dr. Stephen Harris is affiliated with Good Samaritan Hospital and Southside Hospital.

Please feel free to discuss this policy with Joanne Parrinello or Dr. Harris in order that we may assist you in this matter. ***By signing this form, I fully understand and agree to the above stated office policy.***

_____ _____

Patient Signature **DATE**