**VOLUNTARY USE OF OUT-OF-NETWORK BENEFITS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Consent that Dr. John Brian Boyd will be providing services for office visits/procedures and I am aware that Dr Boyd is not contracted with (insurance company) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Dr. Boyd is considered an out of network provider) and its affiliates.

I consent to any procedures performed by Dr. John Brian Boyd as an out of network provider and assume any financial responsibly after my insurance company pays their ‘reasonable/customary/allowed amount’ fees, that I am aware and responsible for any balance based on the billed fees.

I acknowledge and Consent that I am aware that if I see an in-network care provider, benefits are available for lower out-of-pocket costs to me.

I acknowledge and consent that I have been informed that Out of Network costs will not count toward annual maximum out-of-pocket for in-network benefits or deductibles. They will count toward out-of-network benefits/annual maximum out of pocket or deductibles.

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Patient/Member Signature Date Signed

Or Legal Guardian