CASTELLINI CARE red bank
acupuncture
chiropractic
physical therapy
active release

206 Broad Street•Red Bank•NJ•07701
(PHONE) 732-219-1900 (FAX) 732-219-0202
www.castellinicare.com

Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act - Assembly Bill 2039

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and facilities with which the professional is affiliated with. In compliance with these laws, and the undersigned patient is hereby notified, in writing that:

Health Plans our Practice Participates With:

QualCare	**PO Box 249, Piscataway, NJ 08855**
Oxford	**PO Box 7082, Bridgeport, CT 06601**
United Healthcare	**PO Box 30555, Salt Lake City, UT 84130**
GHI	**PO Box 3000, New York, NY 10116**

If the patient's health plan is not listed above, the physician and/or providing service do not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan:
   Out- of- Network Patients **In-Network Patients**
   Patient initials: _____ (or) N/A: _____

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request:
   Out- of- Network Patients **In-Network Patients**
   Patient initials: _____ (or) N/A: _____

3) I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided:
   Out- of- Network Patients **In-Network Patients**

   Patient initials: _____ (or) N/A: _____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.
   Out- of- Network Patients **In-Network Patients**

   Patient initials: _____ (or) N/A: _____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.
   Out- of- Network Patients **In-Network Patients**

   Patient initials: _____ (or) N/A: _____

The Health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures – **OUT-OF-NETWORK PATIENTS**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: _____ Date: _____

Print Name: _____

Acknowledgement of Receipt of Disclosures – **IN-NETWORK PATIENTS**

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I understand that currently my out of pocket expenses will be limited to those described in my insurance policy and the contractual obligations between the health care provider and my insurance carrier. The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professionals' changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: _____ Date: _____

Print Name: _____