



PEDIATRIC AND ADULT EAR, NOSE & THROAT

**OUT OF NETWORK WAIVER**

I, \_\_\_\_\_, understand that I am covered under an insurance plan that the physicians of Ohio ENT do not participate with and I am choosing to obtain services that will be considered out of network. I have been informed and completely understand that Ohio ENT is NOT a participating provider with my insurance, therefore, I am fully responsible for the charges incurred and will pay at the time of service. I also understand that a claim *will not* be submitted to my insurance plan.

I also understand that this will be for the duration of my treatment with Ohio ENT or until my insurance carrier changes.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

Estimated services and associated fees for:

_____	_____
_____	_____
_____	_____
_____	_____

\*\*\*If your insurance plan provides out of network benefits you can submit these charges on your own for reimbursement. A receipt will be provided by Ohio ENT for such purpose\*\*\*