FREEDOM
Surgical Center, LLC

NEW JERSEY OUT-OF-NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT AND ACCOUNTABILITY ACT DISCLOSURE

By my signature below, I confirm that, prior to my scheduled procedure, I was notified and/or advised:

a) Whether Freedom Surgical Center is in-network or out-of-network with respect to my health benefits plan. I have received either an out-of-network letter outlining Freedom Surgical Center's out-of-network policy or confirmation that the facility is participating with my health benefits plan.

b) To contact my physician's office to determine whether my physician is in-network or out-of-network with respect to my health benefits plan. I understand that Freedom Surgical Center will also provide me with information on how to determine the health benefit plans participated in by a physician reasonably expected to provide services to me at Freedom Surgical Center.

c) That if Freedom Surgical Center is **in-network** and participating with my health benefits plan:
   i) I will have a financial responsibility applicable to an in-network procedure and not in excess of my copayment, deductible, or coinsurance as provided in my health benefits plan.
   ii) I will not incur any out-of-pocket costs in excess of the charges applicable to an in-network procedure, unless I, at the time of this disclosure knowingly, voluntarily, and specifically selected an out-of-network provider to provide services.
   iii) Any bills, charges or attempts to collect by Freedom Surgical Center, or any health care professional involved in the procedure, in excess of my copayment, deductible, or coinsurance as provided in my health benefits plan in violation of subparagraph (ii) of this paragraph should be reported to my insurance and the relevant regulatory entity; and
   iv) If my coverage is provided through an entity providing or administering a self-funded health benefits plan that does not elect to be subject to the provisions of section 9 of the Out-of-Network Consumer Protection Transparency, Cost Containment and Accountability Act, that:
      (1) Certain health care services may be provided on an out-of-network basis, including those services associated with Freedom Surgical Center;
      (2) I may have a financial responsibility applicable to health care services provided by an out-of-network provider, in excess of my copayment, deductible, or coinsurance, and I may be responsible for any costs in excess of those allowed by my self-funded health benefits plan;
      (3) I may contact my self-funded health benefits plan sponsor for further consultation on those costs, if needed.

d) I understand that if Freedom Surgical Center is **out-of-network** with respect to my health benefits plan:
   i) Certain health care services may be provided on an out-of-network basis, including those health care services associated with the Freedom Surgical Center;
   ii) I may have a financial responsibility applicable to health care services provided by at an out-of-network provider in excess of my copayment, deductible, or coinsurance, and I may be responsible for any costs in excess of those allowed by my health benefits plan; and
   iii) I should contact my insurance carrier for further consultation on those costs, if needed.

e) I understand that Freedom Surgical Center's charges are available to me upon request.

By my signature below, I hereby acknowledge that I have read and understand this New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act Disclosure

_____

NAME OF PATIENT

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & RELATIONSHIP DATE

_____ _____

WITNESS DATE

Freedom Surgical Center
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