

**Notice Pursuant to the New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act**

Health Service Provider \_\_\_\_\_

Patient Name: \_\_\_\_\_

Health Benefit Insurer: \_\_\_\_\_

Services Provided are billed to \_\_\_\_\_ “In Network” Health Care Provider

\_\_\_\_\_ “Out of Network” Health Care Provider

**Notice to Patient if Acupuncture Services are billed to an “In Network” Health Insurance Provider**

Please be advised that your procedures are considered “In Network” and you will not have any financial responsibility applicable to the in-network procedures provided by our office in excess of your copayment, deductible, or coinsurance as provided in your health benefits plan and you will not incur any out-of-pocket costs in excess of the charges applicable to an “In-Network” procedure; and that

Any bills, charges or attempts to collect payment for services by our office in excess of your copayment, deductible, or coinsurance as provided in your health benefits plan is in violation of the New Jersey Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act and should be reported to your Health Insurance Plan provider and also to the New Jersey Department of Banking and Insurance at (609) 292-7272.

**Notice to Patient if Acupuncture Services are billed to an “Out of Network” Health Insurance Provider**

Please be advised that certain health care services will be provided on an out-of-network basis, including those health care services associated with our office; and

You will have a financial responsibility applicable to all health care services provided by our office in excess of your copayment, deductible, or coinsurance, and you will be responsible for any costs in excess of those allowed by the “Out of Network” health benefits plan. And furthermore;

You should contact your Health Insurance carrier for further consultation on those costs.

**Further Notices:**

Please be advised that we participate and are “In Network” with the following Health Care Benefit Plans

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A complete list of our “In Network” Health benefit Plan participation can be found on our website at \_\_\_\_\_

Please be informed that our fee estimate for your health services is available upon request and we will also provide the Current Procedural Technology (“CPT”) codes associated with our service upon your request.

I hereby request a Fee Estimate and the CPT Codes associated with my treatment.

Yes \_\_\_\_\_

No \_\_\_\_\_

I hereby acknowledge receipt of the above information as required by New Jersey State Law and hereby acknowledge that this notice shall apply to all future treatments with the above noted Health Service Provider. If the Network Status of the patient or Health Service provider changes during the course of my treatment the Health Service Provider shall promptly inform me of this change of status.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient