Disclosure of Financial Interest and Out of Network Election

"In addition to such other information as the board determines necessary, the disclosure shall inform the patient whether any services or facility fees associated with the referral will be considered to be, and reimbursed at, an "out-of-network" level by the patient's insurance carrier or third party payer (cf: P.L. 1989, c. 19, s. 3)."

"disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L. 1989, c. 19 (C.45:9-22.6)."

Public law of the State of New Jersey and rules of the Board of Medical Examiners mandates that a physician, podiatrist, and all other licensees of the Board of Medical Examiners inform patients of any significant and beneficial interest held in a healthcare service.

Accordingly, take notice that practitioners in this office do have a significant beneficial interest in the following healthcare service(s) to which patients are referred:

PREMIER SURGICAL CENTER

This basically means that the doctor is an owner/partner in the surgery center you are being referred to, and you may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care providers can be found in the classified section of your telephone directory under the appropriate heading.

I have discussed with my physician or his/her representative the healthcare service that he or she will provide to me in connection with my treatment and I understand that services or facility fees associated with my referral to the above named facility will be considered to be, and reimbursed at an "out of network" level by my insurance carrier or other third party payer (cf: P.L. 1989 c. 19, s. 3).

Additional CMS (Medicare) Requirements – effective 5/18/2009:
I hereby acknowledge receipt of the "Patient's Rights", "Advance Directives", and "Ownership Disclosure".

Patient Name (printed) _____

Patient Signature: _____ Date: _____