[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Notification of Out-of-Network Status and Financial Responsibility

Dear [Patient Name],

This letter is to inform you that [Provider/Facility Name] is an **out-of-network** provider for your insurance plan, [Insurance Company Name].

Before proceeding with your care, we want to ensure you understand your financial obligations:

- **Higher Out-of-Pocket Costs:** Because we are out-of-network, your insurance plan may pay a lower percentage of the cost, or nothing at all.
- **Deductibles and Co-insurance:** You may be required to meet a higher out-of-network deductible.
- **Balance Billing:** You will be responsible for the difference between our charged amount and the amount your insurance company chooses to pay (except where prohibited by law, such as under the No Surprises Act).

Estimated Cost of Service: $[Estimated Amount]

Please note that this is only an estimate. The final amount may vary based on the actual services provided. We recommend that you contact your insurance provider directly to confirm your "out-of-network" benefits and determine your exact coverage levels.

By signing below, you acknowledge that you have been informed of our out-of-network status and accept full financial responsibility for all charges not covered by your insurance provider.

Sincerely,

[Staff Name/Billing Department]
[Practice Name]

Patient Acknowledgment:

I have read the above information and understand that I am responsible for all costs associated with my care that are not paid by my insurance company.

Signature: _____ Date: _____