East Orange
General Hospital

ACKNOWLEDGEMENT OF DISCLOSURE NOTICES: IN-NETWORK FACILITY

I, _____ have been notified that this facility is **in network** with my health insurance plan. I was also informed that I:

- ✓ *Should contact the physician ordering the healthcare services to determine whether that physician is in network or out of network.*
- ✓ *Can find information on the insurance plans that the hospital's employed and contracted physicians participate with on the facility's website at www.EOGH.org.*
- ✓ *Will not pay more than the in-network copayment, deductible or coinsurance unless I specifically select an out-of-network healthcare professional, which may lead to higher out-of-pocket costs.*
- ✓ *Should notify my health insurance plan and the Department of Health if I receive any in-network medical bills for more than my copayment, deductible or coinsurance and I did not knowingly and voluntarily select an out-of-network provider.*
- ✓ *Will be notified if the network status of the facility changes.*

I have received a copy of this disclosure for my records.

_____
Print Name

_____
Signature

_____
Date

East Orange
General Hospital

OUT-OF-NETWORK FACILITY

I, _____ have been notified that this facility is **out of network** with my health insurance plan. I was also informed I:

- ✓ *May receive certain services on an out-of-network basis, including services associated with the facility.*
- ✓ *May be charged more than the in-network copayment, coinsurance or deductible.*
- ✓ *May be charged for the amount between what the insurance company determines it will pay the facility and what the facility charges:*
- ✓ *Should contact my insurance company for more information on costs:*
- ✓ *Should check with the physician ordering the healthcare services to determine if that physician is in network or out of network with my health insurance plan:*
- ✓ *Can find information on the insurance plans that the hospital's employed and contracted physicians participate with on the facility's website at www.EOGH.org.*

I have received a copy of this disclosure for my records.

_____
Print Name

_____
Signature

_____
Date

This notice is only required when scheduling an appointment for a non-emergent or elective service. It should not be used in emergent or urgent situations.

East Orange
General Hospital

ACKNOWLEDGEMENT OF DISCLOSURE NOTICES: SELF-FUNDED PLANS

I, _____ have been notified that this facility is **unable to determine the network status** of my health insurance plan because I have a self-funded plan. I was also informed that I:

- ✓ *Should contact the physician ordering the healthcare services to determine whether that physician is in network or out of network:*
- ✓ *May receive certain services on an out-of-network basis, including services associated with the facility:*
- ✓ *May have a financial responsibility for the services provided by an out-of-network physician, hospital or surgery center that may be more than my in-network copayment, deductible or coinsurance:*
- ✓ *May be responsible for any costs that exceed the amount paid by my insurance plan:*
- ✓ *Should contact my employer for more information on potential out-of-pocket expenses.*

I have received a copy of this disclosure for my records.

_____
Print Name

_____
Signature

_____
Date

This notice is only required when scheduling an appointment for a non-emergent or elective service. It should not be used in emergent or urgent situations.