Circle of Life Counseling, LLC

Dorith Prutchi, MSS, LCSW – Licensed Clinical Social Worker

ACKNOWLEDGEMENT OF SELECTION OF OUT-OF-NETWORK PROVIDER SERVICES

Client Name: ____________________________________

Health Benefits Plan or Self-Funded Plan: ____

I, the undersigned, specifically request the services of Dorith Prutchi, MSS, LCSW, of Circle of Life Counseling, LLC ("the Practice"), whom I have been advised does not participate, and is "out-of-network", with my health benefits plan or self-funded plan.

I understand that I may owe more than the copayment, deductible, and/or coinsurance amount of my health benefits plan or self-funded plan.

I further understand that I may be charged the difference between what my health benefits plan or my self-funded plan pays the Practice and what the Practice charges me for the services provided.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associated with the services I receive from the Practice and that I am ultimately responsible for the cost of services received from the Practice.

Client or Responsible Party Signature: ____

Responsible Party's printed name and relationship to Client: _____________________________________
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Date: ______________________________