KATY
Pain and Spine

☐ **Karan Madan, MD.** ☐ **Nimish Davé, MD.**
☐ **Dawnna Walton, MD.**

Disclosure and Authorization Form for Patient Referral to Other Non-participating Physicians or Facilities Advocacy for patient Freedom of Choice for Provider

Patient Name: _____

Patient Plan In-Network: _____ Diagnosis:_____

Treatment: _____

In order to better serve you with the highest quality care and safety at the most affordable costs, sometimes it is necessary and important to have other additional providers/entities to join our team to complete or continue your medical procedures or treatment in order to ensure speedy recovery for you. We would like to keep you informed of your choice in and our recommendation of these other providers/entities and obtain your informed consent before our referral and scheduling for your next procedure. While no provider/entity could be participating in every managed care network, such as the one your health plan has contracted with, these other providers/entities may or may not be in your health plan network. This Disclosure and Authorization form is used to inform you of our verification that the above name providers/entities are or may be non-participating providers/entities with your health plan.

We have verified your insurance coverage for non-participating providers/entities and the recommended treatment/procedures and obtained pre-certification if applicable for all services as a courtesy to you. Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider/entity, please call the member services number on your Insurance card.

Compliance & Disclosure under Texas Occupations Code –Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor/facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of providers/entities/facilities: (A) affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive directly or indirectly remuneration for referring upon my such request and exercising my right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

Facility with affiliation & remuneration:
Comfort Care Anesthesia PLLC, Pin Oak Medical Center, POK Medical Center.
Any other physicians or Providers contracted by or affiliated with these providers/entities.
Any other Physician Owned Entity that may have been referred to by these providers/entities.

*I certify that the Advocacy for Patient Freedom of Choice for Providers with the above specific disclosure from my providers is in full compliance with the Section 102.006 of Texas Occupations Code, in a manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure, or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

*I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

*I certify that my attending physician has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage. ***I have read and fully understand the Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network providers/entities as named above.**

_____	_____	_____
Signature	**Patient Name**	**Date**

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Member Advance Notice Form for the Involvement of a Non-Participating Provider

Your physician or other health care professional has decided to involve a non-participating physician, facility or other provider in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your option to utilize a participating provider and you have agreed to receive services from a non-participating provider despite potential increased out-of-pocket costs associated with that decision.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. However, it is important you understand that you may have higher out-of-pocket costs when using a non-participating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a nonparticipating provider, you may be responsible for the entire cost of the services. If you have questions or would like to find a participating provider that can perform the services you require, please ask your physician or other health care professional to arrange for the use of a participating provider. You can confirm the participation status of providers by contacting your insurance plan at the telephone number on the back of your health plan ID card. You may also log on to most insurance websites to search the online provider directory for a participating provider in your area.

To be completed by the member's physician or other health care professional:

Member Name: _____Member ID #:_____

Physician Name and Tax ID#: Karan Madan MD (TIN# 473215287),
Non-Participating Physician/Facility Name: *Pin Oak Medical Center, POK Medical Center, Comfort Care Anesthesia, PLLC.*

Physician Name and Tax ID#: Nimish Davé, MD (TIN# 473215287),
Non-Participating Physician/Facility Name: *Pin Oak Medical Center, POK Medical Center,*

Physician Name and Tax ID#: Dawnna Walton, MD (TIN# 473215287),
Non-Participating Physician/Facility Name: *Pin Oak Medical Center, POK Medical Center,*

Type of Service Non-Participating Provider to Render: Pain Management Injection/Services, SCS/DCS Trials
Reason Involving Non-Participating Provider: Proximity, provider reputation, patient convenience, care quality

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To be completed by the member or the member's legal guardian:

I am aware that the physician, facility or other health care provider listed above will be involved in my care on the date of service listed above and I understand that this health care provider is not a participating provider in my insurance network. I was provided and declined the opportunity to select a participating provider to provide the health care services indicated above and am voluntarily choosing to obtain services from a non-participating provider. I am aware that I may be responsible for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan. I understand that non-participating providers are generally prohibited from waiving member cost share amounts such as copayments, deductibles, coinsurance.

_____

Signature of Member or Legal Guardian **Printed Name of Member**

_____

Date **Telephone Number**