SUFFOLK SURGERY CENTER

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NOTICE OF RIGHT TO REQUEST INFORMATION ABOUT THE AMOUNT OR THE ESTIMATED AMOUNT THAT SUFFOLK SURGERY CENTER WILL BILL YOU IF SUFFOLK SURGERY CENTER IS NOT A PARTICIPATING PROVIDER IN YOUR HEALTH INSURANCE PLAN

Effective Date: 03/30/2015

IN ACCORDANCE WITH NEW YORK LAW, YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE PRIOR TO THE PROVISION OF NON-EMERGENCY SERVICES BY SUFFOLK SURGERY CENTER.

(1) **IF SUFFOLK SURGERY CENTER IS NOT A PARTICIPATING PROVIDER IN YOUR HEALTH INSURANCE PLAN**, THEN INFORMATION REGARDING THE AMOUNT OR ESTIMATED AMOUNT THAT SUFFOLK SURGERY CENTER WILL BILL YOU FOR MEDICAL SERVICES **IS AVAILABLE TO YOU UPON REQUEST** (SO LONG AS THE MEDICAL SERVICE IS NOT AN EMERGENCY SERVICE).

(2) UPON RECEIPT OF SUCH A REQUEST FROM YOU, SUFFOLK SURGERY CENTER MUST DISCLOSE TO YOU IN WRITING THE AMOUNT OR ESTIMATED AMOUNT THAT IT WILL BILL YOU FOR THE MEDICAL SERVICES PROVIDED OR ANTICIPATED TO BE PROVIDED TO YOU, ABSENT UNFORESEEN MEDICAL CIRCUMSTANCES THAT MAY ARISE WHEN THE SERVICES ARE PROVIDED.

THIS ONLY APPLIES IF SUFFOLK SURGERY CENTER IS NOT A PARTICIPATING PROVIDER IN YOUR HEALTH INSURANCE PLAN

Patient Acknowledgement of Receipt of Notice of Right to Request Information from Suffolk Surgery Center about the Amount or Estimated Amount that Suffolk Surgery Center will bill you directly for Medical Services

This Notice provides information to you about your right to request from Suffolk Surgery Center information about the amount or estimated that Suffolk Surgery Center will bill you directly for Medical Services **if Suffolk Surgery Center is not a participating provider in your Health Insurance Plan**.

By signing this form, you acknowledge that you have received this Notice of Your Right to Request Information from Suffolk Surgery Center about the Amount or Estimated Amount that Suffolk Surgery Center will bill you directly for Medical Services.

_____

Name of Patient or Patient Representative

_____

Signature of Patient or Patient Representative

Date: _____

THE AMOUNT OR ESTIMATED AMOUNT THAT SUFFOLK SURGERY CENTER WILL BILL YOU **BECAUSE IT IS NOT A PARTICIPATING PROVIDER IN YOUR HEALTH INSURANCE PLAN IS**:

Description of Service: _____

_____

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Amount or Estimated Amount to be Billed Directly to You: _____