Align Clinic, LLC

Out-of-Network Provider Notification

I acknowledge that Align Clinic, LLC has informed me that it is an out-of-network provider with my insurance plan. I consent to continue my treatment with Align Clinic and accept out-of-network coverage as quoted by the Align Clinic staff and as finalized by my insurance company upon claim submission.

In many situations involving claims billed out-of-network, the insurance company will send payment for the claim by check to the plan subscriber, rather than directly to Align Clinic LLC, the provider. In the event that this occurs, I agree to deposit this payment, and then send a check for the payment amount, along with any remaining balance, payable to Align Clinic, LLC as soon as I receive said payment.

Furthermore, I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

_____

Date