CYPRESS HEART & VASCULAR CENTER

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GENERAL DISCLOSURE REGARDING NORTH CYPRESS MEDICAL CENTER

I understand that if North Cypress Medical Center is out of network with my insurance plan, I will be eligible for a significant prompt pay discount by paying on a timely basis.

I understand that if I have any questions or concerns about this, I can confer with my doctor or the North Cypress Medical Center business office prior to any services being rendered.

I understand that North Cypress Medical Center is a physician owned and operated hospital and that Dr. Alameddine has an ownership interest in the hospital.

I also understand that my doctor is an attending physician at hospitals that may be out of network with my insurance plan.

I understand that I have the option to get my care at either an in network or an out of network facility and that if I have any questions regarding this, I can ask my doctor or the business office for further information.

PLEASE SIGN IN ACKNOWLEGEMENT THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____