

**Wesley A. King, M.D.**

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**OUT OF NETWORK BENEFITS**

**I understand that I have an insurance policy, which allows me to use both in network and out of network providers.**

\_\_\_\_\_ **At this time, I am choosing the OUT OF NETWORK benefits of my insurance policy. Where I can chose any doctor of my choice with no authorization. I fully understand that I may be responsible to pay a yearly deductible, co-payments and any portion that is not covered by my insurance company.**

**NON PROVIDER**

\_\_\_\_\_ **At this time, I am choosing Dr. King as my neurosurgeon. I am fully aware Dr. King is a non provider for my insurance company. Therefore I will be responsible for a higher co-payment, deductible or any portion not covered by insurance company.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_