



**BASTIAN  
VOICE INSTITUTE**  
*for voice, swallowing & airway disorders*

**OUT OF NETWORK INSURANCE CONFIRMATION**

This is confirmation that \_\_\_\_\_ arrived  
(Patient Name)  
at Bastian Voice Institute today, \_\_\_\_\_ with insurance  
(Date)  
coverage from \_\_\_\_\_. The guarantor  
(Insurance Carrier)  
and/or patient has been notified that Bastian Voice Institute does not participate  
with this insurance plan and that benefits will therefore be paid at a lower level or  
may be applied to an out-of-network deductible. The patient and/or guarantor  
acknowledges this and has chosen to be seen by the physician.

\_\_\_\_\_  
Patient/Guarantor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date