



## Greater Baltimore Medical Associates

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to seeing you at your scheduled appointment.

To save time on the day of your visit, please print and complete the forms found on the 'New Patient Packet' page on our website. Bring the forms with you on the day of your scheduled appointment. We realize there are many forms to complete, and we appreciate your patience and cooperation. In order to provide you with the best medical care possible, these forms are an important part of your record. Additionally, in order to be in compliance with federal, state, and hospital policies, these documents are required.

If your insurance is an HMO or Managed Care plan, it is your responsibility to obtain the necessary referral form or pre-authorization for your visit. Under the terms of your plan, the doctor will not be able to see you without necessary referrals. Co-payment for services will be collected at the time of service. Please bring your insurance cards and a photo ID with you at the time of your appointment.

Thank you for making an appointment with Greater Baltimore Medical Associates. If you have any questions, or if you need to change your appointment, please contact our office. Also, please take a moment to explore the GBMC website at [www.gbmc.org](http://www.gbmc.org) and take a look at the many services available to you at Greater Baltimore Medical Center. To view an interactive map of the GBMC campus, please click on the following link: <http://www.gbmc.org/MapDirectionsParking>

We look forward to seeing you soon.

Sincerely

Greater Baltimore Medical Associates

**REVIEW WITH PATIENT DURING EACH VISIT**

**Authorization for Release of Protected Health Information to a Spokesperson** *As stated in the Greater Baltimore Medical Center's (GBMC) Notice of Privacy Practices, "we may release health information about you to a family member, other relative, or any other person identified by you who is involved in your care with your permission."*

**By signing this authorization, I allow GBMC to tell the spokesperson(s) named below the following information:**

- My x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plan either in person or by telephone.

**By signing this authorization, I understand the following:**

- This applies to services being rendered to me by the GBMC physician practice named below:  
\_\_\_\_\_.
- This authorization is voluntary.
- Once this information is released to the spokesperson(s), the released information may no longer be protected by the federal privacy regulations.
- The spokesperson(s), medical power of attorney, health care agent or other individual allowed by law will be the only person(s) who may obtain specific information about me.
- My spokesperson(s) does not have decision-making abilities unless he/she is able to do that as set forth in the law.
- This authorization will expire one year from the date signed below unless a specific expiration event or condition is named here:\_\_\_\_\_.
- I may withdraw this authorization at any time by notifying the GBMC Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by GBMC prior to receiving the written request.
- My treatment will not be affected by me choosing to sign or not to sign this document.
- I may refuse to sign this authorization.

**YOU WILL RECEIVE A COPY OF THIS FORM ONCE IT IS COMPLETED**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Spokesperson Information: PRINT CLEARLY**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

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

\_\_\_\_\_  
**Printed name of Patient's Representative**

\_\_\_\_\_  
**Relationship to Patient**



## GBMA Physician Enterprise

### Financial Policy Insured Patients

Thank you for choosing us as your medical care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. Always bring your insurance card with you when you come in for a visit. If you are not insured by a plan we do business with, payment is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contractual agreement with your insurance company. Please help us by paying your co-payment at each visit.
3. **Acceptable forms of payment.** We accept cash, check, money order, Visa and MasterCard. A fee of \$30 will be assessed for each personal check returned by your bank as *non-sufficient funds*.
4. **Referrals.** It is your responsibility to know whether your insurance carrier requires a referral and to bring it with you at the time of service. If you don't bring a needed referral, we will ask you to sign a Referral Waiver if you want to receive services that day. If you are not able to supply a referral from your primary care physician within five business days, you will be responsible for full payment for the service.
5. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be *noncovered or not considered reasonable or necessary* by your insurance company. The fact that the insurance company doesn't cover the service doesn't mean that you don't need it. Your doctor will explain why he or she thinks that you can benefit from a service or procedure. If you elect to have the non-covered service, you must pay at the time of visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
6. **Medicare patients:** If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision.
7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
8. **Coverage changes.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.



## GBMA Physician Enterprise

9. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be assessed a 30% surcharge to cover agency fees. You will receive a statement of your account each month. If your account is over 90 days past due, the message on your statement will say that your account is being reviewed for placement with a collection agency and you have 10 days to send payment in full. Partial payments will not be accepted unless otherwise negotiated. Extended payments need to be discussed with the billing office at 443-204-8249.
10. **Telephone Calls.** We understand that there are times that you may need to consult your physician by telephone. When those telephone consultations are not the result of a visit that occurred in the previous seven (7) days, or do not result in a visit in the next three (3) days, there will be a charge for these consultations based on the length of time of the call. Charges may range from \$25 to a maximum of \$60. Some insurance carriers, especially Medicare, may consider these services as “noncovered”. The charges will be your responsibility.
11. **Missed appointments.** We reserve the right to charge for missed appointments and those that are canceled within 24 hours of the date of the appointment. Our fee is \$75 for new visits and \$50 for return visits. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or canceling with us at least 24 hours in advance.
12. **Forms Completion.** We reserve the right to charge for completion of forms (disability, MVA, etc.) because it requires time and resources that are in scarce supply. Our fee for simple, single page forms is \$10 each. Our fee for complex, multi-page forms is \$25 each. Fees must be paid in full at the time of service.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. If you have any questions or concerns, please contact our **billing office at 443-204-8249**. Representatives are available to assist you **Monday through Friday from 8:30 am until 4:00 pm**.

All payments and correspondence should be mailed to:

GBMC Agency, Inc.  
PO Box 631568  
Baltimore, MD 21263

**I have read and understand the GBMC Faculty Financial Policy and agree to abide by its guidelines:**

\_\_\_\_\_  
**Signature of patient or responsible party**

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

GBMC HealthCare Patient  
6701 North Charles Street  
Baltimore, MD 21204

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS** – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney’s fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), “opt-out” plan, “out-of-network” preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General’s Office to learn how to appeal adverse decisions made by my insurer.

**MEDICARE/MEDICAID PATIENT CERTIFICATION** – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

#### **PERMISSIONS / ACKNOWLEDGEMENTS**

**USE AND DISCLOSURE OF HEALTH INFORMATION** – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information (including information related to psychiatry, drug abuse, alcoholism, or HIV testing) for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information to other health care providers for continuing care and treatment.

**Assignment of Benefits form physician practices**

GBMC HealthCare  
6701 North Charles Street  
Baltimore, MD 21204

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PRE-CERTIFICATION REQUIREMENTS** – If my insurance company or third-party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification.  
EXCEPTION: Medicare

**AUTHORIZATION FOR TREATMENT-** I authorize \_\_\_\_\_ to provide medical treatment to the patient named on this form.

Has the patient received the Notice of Privacy Practices?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Reason no NOPP given:

\_\_\_\_\_ Newborn

\_\_\_\_\_ Patient Unable to Accept

I have read and understand in its entirety the information provided on this document.

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Signature of Patient or Patient**

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

**Assignment of Benefits form physician practices**



Patient Name:  Mr.  Ms. \_\_\_\_\_  
 Mrs. (Last) (First) (Middle Initial) (Previous Name)

Address Line 1: \_\_\_\_\_ Address Line 2: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Work#: \_\_\_\_\_

PCP: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ [ ] Male [ ] Female SS# \_\_\_\_\_

Email Address: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Marital Status	Race	Ethnicity	Preferred Method of Communication	Employment Status	Student Status
<input type="checkbox"/> Single	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Home #	<input type="checkbox"/> Full time	<input type="checkbox"/> Full time
<input type="checkbox"/> Married	<input type="checkbox"/> Asian	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Cell #	<input type="checkbox"/> Part time	<input type="checkbox"/> Part time
<input type="checkbox"/> Divorced	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Refused to Report	<input type="checkbox"/> Work #	<input type="checkbox"/> Not employed	<input type="checkbox"/> Not a student
<input type="checkbox"/> Widowed	<input type="checkbox"/> Black or African Am.		<input type="checkbox"/> Mail	<input type="checkbox"/> Self employed	
<input type="checkbox"/> Legally Sep	<input type="checkbox"/> White		<input type="checkbox"/> Email	<input type="checkbox"/> Retired	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Hispanic			<input type="checkbox"/> Active Duty	
<input type="checkbox"/> Partner	<input type="checkbox"/> Other Race			<input type="checkbox"/> Military	

Employer Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Dept/Ext: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Claims Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ [ ] Male [ ] Female

Subscriber's Employer \_\_\_\_\_

Subscriber's Employer's Phone # \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Claims Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ [ ] Male [ ] Female

Subscriber's Employer \_\_\_\_\_

Subscriber's Employer's Phone # \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

**Other Insurance Information:**

Do you have any other insurance? If yes, please list: \_\_\_\_\_

Are you here for a Workers Comp Accident [ ] yes [ ] no Personal Injury [ ] yes [ ] no

Are you here for an injury from a motor vehicle accident? [ ] yes [ ] no Other injury? [ ] yes [ ] no

\*\*If yes to either of these questions: **What was your date of injury or accident?** \_\_\_\_\_

How did your injury occur? \_\_\_\_\_

What is your injury or accident claim number? \_\_\_\_\_

What is the name/address of your attorney or insurance company for this claim? \_\_\_\_\_  
Phone #: \_\_\_\_\_

I certify that the demographic and insurance information on this form is current and accurate to the best of my knowledge.

x \_\_\_\_\_  
Signature of Patient and/or Financially Responsible Party Relationship (If 17 yrs or younger) Date

**Please complete ONLY FOR PEDIATRIC PATIENTS If you are not a pediatric patient STOP here:**

<b>Siblings</b> (list all)	<b>Children live with:</b>	<input type="checkbox"/> Parents	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/>	<b>Other</b>
Name _____	DOB _____			Social Security # _____		
Name _____	DOB _____			Social Security # _____		
Name _____	DOB _____			Social Security # _____		
Name _____	DOB _____			Social Security # _____		

=====

**Father's Name** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

=====

**Mother's Name** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

**\*\*Note:** The parent who brings a child to the office for medical services is responsible AT THE TIME OF SERVICE for co-payments, deductibles, balances, or for payment in full, in the event the provider of service is non-participating with your insurance carrier.  
9/20/10

GBMC Physician Enterprise:

\_\_\_\_\_



Patient's Physician: \_\_\_\_\_

For Office Use Only

### MEDICATION LIST

Home medications for reconciliation for present office visit.

Please complete this medication list form. If you are taking more than 10 medications, continue on the next page. Bring this medication list to your appointment.

**Patient Name:** \_\_\_\_\_, \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

**Date of Birth:** \_\_\_\_\_ **Date List Completed:** \_\_\_\_\_

**Person Completing List:** \_\_\_\_\_, \_\_\_\_\_  
(If other than patient) (Last Name) (First Name) (Middle Initial)

Medication	Dose	Frequency	Reason for Medication	Route (for example- by mouth, eye drops, or by injection)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**Over-the-Counter Medications (Drugs), Vitamins, and Herbal Preparations:**

\_\_\_\_\_

**IF YOU TAKE MORE MEDICATIONS, CONTINUE ON REVERSE SIDE**

Form reviewed with patient by: \_\_\_\_\_

GBMC Physician Enterprise:

\_\_\_\_\_



Patient's Physician: \_\_\_\_\_

For Office Use Only

Medication	Dose	Frequency	Reason for Medication	Route (for example- by mouth, eye drops, or by injection)
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
<b>Over-the-Counter Medications (Drugs), Vitamins, and Herbal Preparations:</b>				
_____				

Form reviewed with patient by: \_\_\_\_\_



Please list any operations or hospitalizations you have had:

Year	Operation	Year	Hospitalizations

When was your last exam?

Eye exam:	Mammogram:	Cholesterol check:
Hearing exam:	Pap smear:	Stool check for blood:
Dental exam:	Bone Density Test:	Colonoscopy:
PSA Test:		

Family Medical History: Please list any serious medical conditions

Mother: \_\_\_\_\_ Maternal Grandparents \_\_\_\_\_

Father: \_\_\_\_\_ Paternal Grandparents \_\_\_\_\_

Siblings: \_\_\_\_\_

Prevention History

Yes No

Yes No

Do you wish to be tested for Aids?			Do you wear sunscreen?		
Do you use drugs?			Do you wear a seatbelt?		
Do you work with harmful substances?			Do you wear a helmet?		
Are you in a relationship where you feel hurt/afraid?			Do you have a living will or advanced directives?		
Do you drink alcohol? How much?			Do you exercise? How much?		
Are you pregnant or lactating?			Do you follow a healthy diet?		
			Do you get adequate calcium?		

Vaccination History

Are you up to date with your childhood immunizations?

- Yes (if yes, please provide)
- No

When was your last:

Tetanus shot?	Hepatitis A?	Flu shot?
Chickenpox as a child? Yes/No	Hepatitis B?	PPD or Tuberculosis Test?
Pneumonia shot?		

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_



## GBMA Physician Enterprise

### Financial Policy Uninsured Patients

Thank you for choosing us as your medical care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

We recognize our obligation to the community to provide appropriate medical care regardless of ability to pay and we assist individuals who are unable to pay by applying the objective criteria of our Charity Care policy. If you are in need of assistance, please contact the billing office at 443-204-8439.

1. **Office Visits** - Payment is expected at each visit.
  - a. You must pay at least 60% of the office visit fee up front in order to receive services.
  - b. You are eligible for a Prompt Payment Discount if you pay in full at the time of your visit. The Prompt Pay discount for office visits is 10% of the fee amount.
2. **Elective Surgery** – Pre-payment is expected prior to scheduling.
  - a. You must pre-pay at least 75% of the estimated fee before the surgery will be scheduled.
  - b. You are eligible for a Prompt Payment Discount of 25% if you pay in full prior to the date of surgery.  
*This covers only the surgeon's fee. You must make payment arrangements with the Hospital or Ambulatory Surgical Center for the facility fees. The number to call at GBMC is 410-560-2450.*
3. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be assessed a 30% surcharge to cover agency fees. You will receive a statement of your account each month. If your account is over 90 days past due, the message on your statement will say that your account is being reviewed for placement with a collection agency and you have ten (10) days to send payment in full. Partial payments will not be accepted unless otherwise negotiated. Extended payments need to be discussed with the billing office at 443-204-8249.
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All payments and correspondence should be mailed to:

GBMC Agency, Inc.  
PO Box 631568  
Baltimore, MD 21263

**I have read and understand the GBMC Faculty Financial Policy and agree to abide by its guidelines:**

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**Signature of patient or responsible party**

---

**Date**

## VOLUNTARY WAIVER OF HMO BENEFITS

(Signing this document will alter your legal rights under Maryland law. Please read carefully and do not sign unless you understand the document.)

I, \_\_\_\_\_ (patient name)  
am seeking medical treatment from \_\_\_\_\_ (“My Physician”).

### Check one

I am not a member of a Health Maintenance Organization (“HMO”) and will be responsible for the payment of any amounts owed to My Physician for services provided.

### OR

I am a member of an HMO but do not have the required referral from my Primary Care Physician (PCP) for today’s visit. I have been informed that if My Physician provides services to me without the required referral, I will be billed at My Physician’s usual rate and I, instead of my HMO, will be responsible for full payment of that bill.

I understand that if, instead of receiving treatment from My Physician today, I had elected to obtain treatment at a later date, after obtaining a referral from my PCP, and the HMO determined that the service was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in my plan.

### OR

I am a member of an HMO but I have been informed that My Physician is not a participating physician with that HMO and that if My Physician provides services to me I will be billed at My Physician’s usual rate and I, instead of my HMO, will be responsible for full payment of that bill.

I understand that if, instead of receiving treatment from My Physician, I had elected to obtain treatment from a health care provider participating in my HMO and the HMO determined that the service was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in my plan

Therefore, this means that

1. I will be solely responsible for My Physician’s charges;
2. My Physician will not seek payment from my HMO.

\_\_\_\_\_  
(Patient signature)

\_\_\_\_\_  
(Date)

