JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS MEDICINE

- ☐ Johns Hopkins Hospital
- ☐ Johns Hopkins Bayview Medical Center
- ☐ Johns Hopkins Community Physicians
- ☐ Johns Hopkins Univ. School of Medicine
- ☐ Howard County General Hospital
- ☐ Ophthalmology Associates
- ☐ White Marsh ASC

Patient's Label Here or Addressograph

JOHNS HOPKINS PRIVATE CONTRACT FOR HEALTHCARE SERVICES *(NOT FOR MEDICAID OR MEDICARE PATIENTS)*

I. I am enrolled in _____ ("Health Plan"). I am asking the Johns Hopkins provider(s) noted below to provide health care services to me under the following circumstances:

Dates of Service/Procedure	Johns Hopkins Provider Name(s)	Service/Procedure
_____	_____	_____
	Johns Hopkins Provider/Department	
_____	_____	_____
	Facility	

II. I acknowledge that one of the following circumstances applies to me:

☐ **A. NON-CONTRACTED SERVICES**

Johns Hopkins does not have a contract with my HMO Health Plan for any service or for the particular type of service I am requesting.

1. I agree that I will pay Johns Hopkins directly for the services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the services I receive.

☐ **B. CHOOSING NOT TO USE INSURANCE**

Johns Hopkins has a contract with my Health Plan but I choose not to use my Health Plan coverage and I agree to pay for the services I receive. This includes services for which my Health Plan requires a referral or authorization and that I choose to have the services without obtaining same.

1. I agree that I will pay Johns Hopkins directly for the services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the services I receive.

☐ **C. NON-PARTICIPATING PHYSICIAN (With no out of network benefit)**

Dr. _____ does not participate with my Health Plan.

1. I agree that I will pay Johns Hopkins directly for the physician services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the physician services I receive, but will send a bill/claim to my Health Plan for any other provider or facility services I receive.

III. I've been given an estimate of the cost for the services I want Johns Hopkins to provide me in the range of $_____ to $_____ . This is an **estimate only** and may vary based upon the actual services provided. Hospital rates may vary due to the regulation of such rates by the State of Maryland.

By signing my name below, I acknowledge that I want to receive services from the Johns Hopkins provider and I understand the terms of this Private Contract.

Patient Name: _____ Signature _____ Date _____
(print)

For healthcare agent/guardian/surrogate/parent, I am the representative to the patient.

Representative Name _____ Signature _____ Date _____
(print)

_____
Witness

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS MEDICINE

- ☐ Johns Hopkins Hospital
- ☐ Johns Hopkins Bayview Medical Center
- ☐ Johns Hopkins Community Physicians
- ☐ Johns Hopkins Univ. School of Medicine
- ☐ Howard County General Hospital
- ☐ Ophthalmology Associates
- ☐ White Marsh ASC

Patient's Label Here or Addressograph

JOHNS HOPKINS PRIVATE CONTRACT FOR HEALTHCARE SERVICES *(NOT FOR MEDICAID OR MEDICARE PATIENTS)*

I. I am enrolled in _____ ("Health Plan"). I am asking the Johns Hopkins provider(s) noted below to provide health care services to me under the following circumstances:

Dates of Service/Procedure	Johns Hopkins Provider Name(s)	Service/Procedure
_____	_____	_____
	Johns Hopkins Provider/Department	
_____	_____	_____
	Facility	

II. I acknowledge that one of the following circumstances applies to me:

☐ **A. NON-CONTRACTED SERVICES**

Johns Hopkins does not have a contract with my HMO Health Plan for any service or for the particular type of service I am requesting.

1. I agree that I will pay Johns Hopkins directly for the services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the services I receive.

☐ **B. CHOOSING NOT TO USE INSURANCE**

Johns Hopkins has a contract with my Health Plan but I choose not to use my Health Plan coverage and I agree to pay for the services I receive. This includes services for which my Health Plan requires a referral or authorization and that I choose to have the services without obtaining same.

1. I agree that I will pay Johns Hopkins directly for the services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the services I receive.

☐ **C. NON-PARTICIPATING PHYSICIAN (With no out of network benefit)**

Dr. _____ does not participate with my Health Plan.

1. I agree that I will pay Johns Hopkins directly for the physician services I receive and that I will not send a bill/claim to my Health Plan for such services.
2. I understand Johns Hopkins will not send a bill/claim to my Health Plan for the physician services I receive, but will send a bill/claim to my Health Plan for any other provider or facility services I receive.

III. I've been given an estimate of the cost for the services I want Johns Hopkins to provide me in the range of $_____ to $_____ . This is an **estimate only** and may vary based upon the actual services provided. Hospital rates may vary due to the regulation of such rates by the State of Maryland.

By signing my name below, I acknowledge that I want to receive services from the Johns Hopkins provider and I understand the terms of this Private Contract.

Patient Name: _____ Signature _____ Date _____
(print)

For healthcare agent/guardian/surrogate/parent, I am the representative to the patient.

Representative Name _____ Signature _____ Date _____
(print)

_____
Witness