JOHNS HOPKINS INSTITUTIONS

Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center
Johns Hopkins Community Physicians
Johns Hopkins Univ. School of Medicine
Howard County General Hospital
Ophthalmology Associates
The Center for Ambulatory Services

JOHNS HOPKINS PRIVATE CONTRACT FOR HEALTHCARE SERVICES

I am enrolled in_____ ("Health Plan") I am asking Johns Hopkins to provide health care services to me without billing that Health Plan for my care:

Department	Date	Service/Procedure
_____	_____	_____

I know that:

(1) Johns Hopkins does not have a contract with my Health Plan, or
(2) Johns Hopkins does not have a contract with my Health Plan for the kind of care I am asking for, or
(3) Dr. _____ does not participate with my Health Plan, and
(4) I have an out-of-network benefit with my Health Plan (Please Circle) YES or NO
(5) Johns Hopkins does have a contract with my Health Plan but I am not asking my Health Plan to pay for the care I want Johns Hopkins to give me, and
(6) I choose not to use my Health Plan and agree to pay for my care myself.

KNOWING ALL OF THIS, I WANT TO ENTER INTO THIS PRIVATE CONTRACT FOR HEALTH CARE SERVICES WITH JOHNS HOPKINS, AND IF I CIRCLED 'NO' ON STEP (4) I WILL NOT USE MY HEALTH PLAN TO PAY FOR ANY CARE I RECEIVE FROM DR. _____.

I agree that I will pay for the services and care rendered at Johns Hopkins.

I agree that I will not ask Johns Hopkins to send a bill to my Health Plan.

I know that Johns Hopkins will not send a bill to my Health Plan or take a payment from my Health Plan for the services and care I request.

I know that the cost for the services and care I want Johns Hopkins to give me will be in the range of $_____.

If I circled 'NO' on step (4) I will not send my Johns Hopkins bill to my Health Plan for payment or reimbursement.

If I circled 'YES' on step (4), I understand that Johns Hopkins will provide a statement to me for my provider services. I understand that I am free to send my Johns Hopkins professional or provider bill to my Health Plan for payment or reimbursement.

If my Johns Hopkins provider is does not participate with my Health Plan, but Hospital based services do, I understand that Johns Hopkins will bill my Health Plan for my hospital based services only.

By signing my name here, I am saying that I understand what I must do under this private contract.

_____ _____
My signature Date