



MIDATLANTIC UROLOGY ASSOCIATES, LLC.

UNITED HEALTHCARE WAIVER

I, _____ (patient's name) am seeking medical treatment from _____ and his associates ("*My Physician*".)

I understand that as of February 1, 2011 that the above-named physician and/or his associates are non-participating with United HealthCare Plans, UHC PPO, UHC HMO, UHC MCO, Mamsi, MD IPA, Optimum Choice, AmeriChoice, and OneNet.

I understand I am being treated by a non-participating physician under my health insurance plan _____ and I will be responsible for full payment for services provided by *My Physician*.

I am a member of _____ plan which allows an Out of Network Option, and I would like to exercise my Out of Network Option for my health care treatment.

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 that plan;

Therefore, this means that

1. I will be solely responsible for *My Physician's* charges, should I elect to be seen by *My Physician* who is a non-participating provider.
2. *My Physician* will seek payment through my Out of Network Benefits if I have that option.

Patient's Signature

Date