



MIDATLANTIC UROLOGY ASSOCIATES, LLC.

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

CHECK ONE

I am not a member of a Health Maintenance Organization ("HMO") Insurance Plan and I will be responsible for the payment of any non-covered services and/or balance not covered by my insurance in any amount owed to *My Physician* for services provided.

OR

I understand I am being treated by a non-participating physician under my health insurance plan _____ and I 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 I have been informed that *My Physician* is not a participating physician with my 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 that 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's Signature

Date