



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.)

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(202) 577-1360

I, \_\_\_\_\_ (patient name)

am seeking medical treatment from

\_\_\_\_\_ and his associates ("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 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 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 mv HMO.

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

\_\_\_\_\_  
Date