JOHNS HOPKINS
MEDICINE

OUTPATIENT AGREEMENT FORM

# OUTPATIENT AGREEMENT FORM

**NAME:**

**DOB:**

**MRN:**

Patient Identification Information



This form applies to the following Johns Hopkins Medicine ("Johns Hopkins") entities: Johns Hopkins Bayview Medical Center, Clinical Practices of the Johns Hopkins University School of Medicine, Howard County General Hospital, Johns Hopkins Community Physicians, Suburban Hospital, Sibley Memorial Hospital, and The Johns Hopkins Hospital, Johns Hopkins Imaging, and Ambulatory Surgery Centers.

**General Policy:** All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.

**Consent for Treatment:** I, or my representative, agree to have Johns Hopkins providers evaluate and treat my condition. Absent an emergency, if the proposed treatment has significant risks, then an additional informed consent will be obtained. I understand that the practice of medicine is not an exact science, and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments or other healthcare services.

**Disclosure & Authorization to Release Information:** I hereby authorize Johns Hopkins to release my final diagnosis and other medical information to third parties to determine benefits payable and process claims. I authorize Johns Hopkins to release medical information to my insurance carrier for payment purposes. I acknowledge that Johns Hopkins and/or any physicians who render services to me may release all or part of my medical and billing records when required or permitted by state and/or federal law or regulation, including as necessary for treatment, payment, and operations.

**Consent to be Contacted:** I agree that by providing my landline or cell phone number(s), I am giving express consent for Johns Hopkins, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers, or any number that is later acquired for me and to leave live or pre-recorded messages or text messages regarding my healthcare-related matters, my account, or my bill related to any services I receive. I confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Providing a telephone or cell phone number is not a condition of receiving services.

**Physicians Not Employees of the Hospital**: I understand that physicians may not be employees of the health system. I understand that my physician may ask other physicians to participate in my care including but not limited to attending physicians, radiologists, surgeons, obstetricians/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and physician assistants. I also agree that physicians in training, students or other qualified health care personnel, under supervision of my physician, may participate in and/or observe my care unless I specifically state otherwise, either verbally or in writing.

**Electronic Prescribing**: I authorize Surescripts, an electronic prescribing network, to release my medication refill history to my providers for the purpose of continued treatment.

**Payment for Services:** I understand that Johns Hopkins may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to Johns Hopkins. If I should receive the payments, I understand that I will be responsible for paying Johns Hopkins. I assign the benefits payable for health care services to the physicians and/or organizations furnishing the services. I authorize direct payment to Johns Hopkins and all other providers of service to me, of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source for the care and services rendered to me or the patient. I assign my right to appeal a denial of payment to Johns Hopkins for services rendered to me.

I understand that Johns Hopkins may be treated as an out of network provider by my health plan for services rendered at Johns Hopkins. In such case, my copay or deductible may be greater than if services were rendered at an in network facility or lab. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefits. I know that I may need to pay this before I am treated.

Patients seen in a clinic or outpatient setting may receive multiple bills. The hospital is permitted to bill a fee for outpatient visits, commonly referred to as a "facility fee", for the use of hospital facilities or space, clinics, supplies, tests, procedures, equipment, and non-physician services, including but not limited to the services of non-physician clinicians. I understand that all professional services of physicians are billed separately from the hospital bill. I understand that I am responsible for the charges of all physicians involved in my treatment.

I understand that hospital rates for hospitals located in the State of Maryland are subject to change without notice during the course of my outpatient treatment. *This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia.*

I understand that at Maryland hospitals I am entitled to a Prompt Payment hospital discount as follows: 2% if payment is made on or before the date of service, or 1% if payment is made within 30 days of the date of the first bill or date of discharge, whichever is earlier. *This does not apply to Sibley Memorial Hospital, a hospital located in the District of Columbia.*

I understand and agree that if my plan does not pay the hospital or doctor, I will have to do so. If my account is sent to a collection agency, I agree to pay all reasonable fees that are required to collect what is due. These fees may include court costs, attorney's fees of 15% of the billed charges and interest at the judicial rate if judgment is entered.

**ERISA:** If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Johns Hopkins act on my behalf to obtain my benefits when Johns Hopkins asks to do so. I also agree that Johns Hopkins can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

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**Private Contract:** I understand that under law Johns Hopkins will hold me responsible in any one of the following situations. I will be asked to review and sign the Private Contract form in addition to this form:

(1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
(2) When I choose not to use my health plan and agree to pay for services myself.
(3) When my health plan does not participate with Johns Hopkins for the services I want or need and I agree to pay for my care myself.
(4) When I receive services that are not covered under my health plan.

**Mediation Agreement (applicable to Maryland only):** I understand that any claim that may arise out of the care provided from the doctors, nurses and other health care providers at any Johns Hopkins entity located in the state of Maryland are governed by the laws of the State of Maryland. I agree that before I file any lawsuit, I will try to resolve my claim through mediation. Mediation is a process through which a neutral third person assists the parties to help settle the claim. I do not give up my right to file a lawsuit if the mediation process fails to resolve my claim. I agree that any mediation or action in court must take place in Maryland. This agreement is binding on me and anyone who makes a claim for me.

**Johns Hopkins Medicare Advantage MD Plans:** I hereby irrevocably assign and transfer to Johns Hopkins, all rights, title and interest in the benefits payable under my Johns Hopkins Medicare Advantage Plan for the treatment rendered to me by Johns Hopkins during this outpatient visit. This irrevocable assignment and transfer shall be for the purpose of granting Johns Hopkins an independent right to recover under such Plan, including but not limited to appeals and/or requests for reconsideration, judicial review of a decision and any other appeal rights to deny benefits and Johns Hopkins agrees to waive any right to payment from the member other than plan-directed cost-sharing associated with the appeal and/or for non-covered charges.

**The Johns Hopkins Notice of Privacy Practices:** I received a copy of the Johns Hopkins Notice of Privacy Practices.

**Other Tests:** In the event that a member of the hospital's work force sustains a bodily fluid exposure during the course of my treatment, I consent to HIV testing and authorize the hospital to release the result of this said test to me, the exposed healthcare employee, and my physician. I understand that I have the right to refuse testing without penalty. _____ **I authorize** _____ **I do not authorize**

**I AGREE TO THE ITEMS STATED ABOVE AND CERTIFY THAT ALL INFORMATION PROVIDED INCLUDING INSURANCE IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

Date:_____ Time:_____ Patient Signature:_____

For health care agent / guardian / surrogate / parent / spouse (circle one), I, _____(print name), am the representative for the patient.

Date:_____ Time:_____ Representative's signature: _____

Relationship to Patient:_____

Date:_____ Time:_____ Johns Hopkins Medicine Hospital Representative Signature_____

Print Johns Hopkins Medicine Representative Name_____

## JOHNS HOPKINS NOTICES

The following notices are being given and are not negated if the patient or patient representative strikes through or crosses out any provision.

**Pathology:** Johns Hopkins may dispose of any tissue or parts that are removed during a procedure; may retain, preserve, use, and share these tissues, parts or related information for internal educational and quality improvement purposes without my permission (even when these tissues, parts or related information identify me); and may use or share tissues, parts or related information that identifies me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If tissues, parts or related information do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

**Personal Belongings:** Patients are responsible for their personal belongings and are encouraged to leave all money and valuables at home. Johns Hopkins shall not be responsible or liable for the loss of or damage to any personal property the patient brought into the facility including but not limited to money, dentures, glasses, hearing aids, personal electronic devices and documents.

**Financial Assistance:** I understand that Johns Hopkins has Financial Assistance Policies which provide financial assistance and payment plans to patients under certain circumstances. I understand that I can request information concerning Johns Hopkins Financial Assistance by contacting the Customer Service Department for Johns Hopkins at 443-997-3370 or 1-855-662-3017. I hereby authorize Johns Hopkins to run a credit report on me for use in determining whether I qualify for financial assistance or a payment plan. I also understand that I can obtain information by going online at: www.hopkinsmedicine.org/patient_care/pay_bill/payment_assistance.html
Physicians have their own financial assistance policies and the patient should contact the physician's office to inquire.

**Advance Directives:** An Advance Directive can mean any written or spoken statement of wishes regarding healthcare that is listed in the medical record. Advance Directives tell your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself. Examples include an appointment of a healthcare agent, healthcare instructions/treatment preferences (e.g., "Living will"), oral Advance Directive, and/or Advance Directive for Mental Health Services. If you have a written Advance Directive, please give a copy to the Registrar, your Nurse or Physician. If you would like to complete an Oral Advance Directive or revoke or revise an existing Advance Directive, please inform the Registrar, your Nurse or Physician.