

## NYU FACULTY GROUP PRACTICE

### **PRIVATE CONTRACT WITH MEDICAID BENEFICIARY**

This agreement is between Dr. \_\_\_\_\_ (“Physician”) and patient \_\_\_\_\_ (“Patient”), with date of birth \_\_\_\_\_ who is Medicaid beneficiary seeking services as a private pay patient, although the services are covered under Medicaid, including Medicaid Managed Care Plans. By signing this Agreement Patient understands and agrees that Patient will be treated on a private pay basis and no Medicaid claim will be filed.

Physician agrees to provide the following medical Services to Patient:

\_\_\_\_\_ Condition of \_\_\_\_\_ to include initial and all follow-up visits for this episode of care.

\_\_\_\_\_ Pre-Op Consultation Date of Service: \_\_\_\_\_

\_\_\_\_\_ Surgery/Post-op (Type: \_\_\_\_\_) Date of Service: \_\_\_\_\_

\_\_\_\_\_ Other (Specify: \_\_\_\_\_) Date of Service: \_\_\_\_\_

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Physician’s fee schedule. The approximate cost for the service above is \_\_\_\_\_; this may vary, however, depending on the actual services required at the time of service.

Patient also agrees, understands and expressly acknowledges the following (please initial each item):

\_\_\_\_\_ Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicaid program with respect to the Services, even if covered by Medicaid.

\_\_\_\_\_ Patient is not currently in an emergency or urgent health care situation.

\_\_\_\_\_ Patient acknowledges that neither Medicaid’s fee limitations nor any other Medicaid reimbursement regulations apply to charges for the Services.

\_\_\_\_\_ Patient acknowledges that he or she has a right, as a Medicaid beneficiary, to obtain Medicaid-covered items and services from physicians and practitioners who participate with Medicaid, and that the patient is not compelled to enter into private contracts that apply to other Medicaid-covered services furnished by other physicians or practitioners who participate with Medicaid.

\_\_\_\_\_ Patient agrees to be responsible to make payment in full for the Services and acknowledges that Physician will not submit a Medicaid claim for the Services and that no Medicaid reimbursement will be provided.

\_\_\_\_\_ Patient understands that Medicaid payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicaid if there was no private contract and a proper Medicaid claim was submitted.

\_\_\_\_\_ Patient acknowledges that a copy of this contract has been made available to him or her.

\_\_\_\_\_ Patient agrees to reimburse Physician for any costs and reasonable attorney fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on \_\_\_\_\_ by:  
(Date)

\_\_\_\_\_ (Patient name) \_\_\_\_\_ (FGP Physician)

\_\_\_\_\_ (Patient Signature) \_\_\_\_\_ (FGP Representative Signature)