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)