JOHNS HOPKINS
MEDICAL INSTITUTIONS

DNA Diagnostic Lab
CMSC 10-106
Johns Hopkins Hospital
600 N. Wolfe St.
Baltimore, MD 21287
Tele: 410-955-0483 FAX: 410-955-0484
email: bkarczes@jhmi.edu

Date:

Patient Name:	**DOB:**

CONSENTS & ASSIGNMENTS – Please Read Before Signing

I understand that if appropriate, Johns Hopkins DNA Diagnostic Lab will bill my Health Plan for services to be rendered. However I also understand that pursuant of Maryland law, Johns Hopkins DNA Diagnostic Lab is authorized to bill me directly under the following conditions.

MEDICAID
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I assign payment for the unpaid charges in hospital physician's services furnished by specialists, and by physicians for whom the Hospital is authorized to bill. I understand that I am responsible for any insurance deductibles and co-insurance.

LEGAL ASSIGNMENTS
The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting there from are considered reasonable by the undersigned, and any and all court costs incurred therewith.

INSURANCE ASSIGNMENT
I authorize and assign payment directly to the physician/physicians/hospital involved in my treatment or my child's treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

SELF-PAY
I understand if I choose to pay for testing at time of service, and if testing is not a covered benefit and/or that without an authorization, I will be financially responsible for charges I incur.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

On Behalf of (if applicable): _____
(Print name of minor or other individual)

Print Name: _____ Date: _____

Signature: _____Daytime Phone Number :_____

Please insert in patient chart, attach a copy to the Pro Fee Billing Voucher. and forward a copy to patient.