



Opt-Out form

Dear Stone Run Family Medicine:

I understand that Maryland Multi-payer Patient Centered Medical Home Program services would be provided to me at no additional charge; however, I choose not to participate in the Program. In opting out of the Program, I understand that I may be relinquishing the additional services outlined in the Program's Commencement Letter.

I have made the decision to opt out of the Program in a completely voluntary manner and not under the influence or direction of any other person.

Patient Signature*

Printed Patient Name

Date

Parent/Guardian Signature*

Printed Parent/Guardian Name

Date

Legal Representative Signature

Printed Legal Representative Name

Date

Please Note:

** If the person signing this form is not the patient, the parent, or a guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e., Power of Attorney, Court Assigned guardian, Personal Representative, etc.)*