PRIVATE CONTRACT WITH MEDICARE BENEFICIARY

| This agreement is between Dr | ("Physician"), whose principal place of business is | |
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| | , and patient | ("Patient"), who |
| that Physician has opted out of the Medicar | and is a Mant to Section 4507 of the Balanced Budget A program effective on// for tB under Sections 1128, 1156, or 1892 or any | a period of at least two years and is not |
| Physician agrees to provide the following m Professional Component Services. | edical services to Patient (the "Services"): Eva | aluation & Management, Consultation and |
| In exchange for the Services, the Patient ag (or any portion thereof) of physician time. | rees to make payments to Physician pursuant | to the Fee Schedule: \$/ minutes |
| Patient also agrees, understands and expres | ssly acknowledges the following: | |
| Patient agrees not to submit a claim (or to Services, even if covered by Medicare Par | request that Physician submit a claim) to the tB. | Medicare program with respect to the |
| • Patient is not currently in an emergency or | urgent health care situation. | |
| • Patient acknowledges that neither Medica for the Services. | re's fee limitations nor any other Medicare re | imbursement regulations apply to charges |
| | will not provide payment or reimbursement ther supplemental insurance plans may likew | |
| physicians and practitioners who have not | right, as a Medicare beneficiary, to obtain Moopted out of Medicare, and that the patient invered services furnished by other physicians of | is not compelled to enter into private |
| • | payment in full for the Services and acknowle o Medicare reimbursement will be provided. | dges that Physician will not submit a |
| · · · · · · · · · · · · · · · · · · · | nt will not be made for any items or services f ere were no private contract and a proper Me | · · · · · · · · · · · · · · · · · · · |
| • Patient acknowledges that a copy of this c | ontract has been made available to him or he | er. |
| Patient agrees to reimburse Physician for a Patient or his beneficiaries. | any costs and reasonable attorney fees that re | esult from violation of this Agreement by |
| Executed on [date] by: | | |
| | [Patient name] | [Physician name |
| | [Patient signature] | [Physician signature |