ATTENTION MEDICARE PATIENTS!!

IF YOU HAVE MEDICARE YOU MUST SIGN THIS FORM IN ORDER TO BE SEEN AT OUR OFFICE

This agreement is between Dr. Howard J. Lang, and Dr. Derek H. Lang, whose principal place of business is 789 Lonesome Dove Trail, Hurst, Texas, and (patient) _____, who resides at _____, and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has **opted out of the Medicare program** originally effective on November 4, 2004. Physician opts out every two years.

Physician agrees to provide medical services to Patient.

In exchange for the Services, the Patient agrees to make payments to the Physician pursuant to the Fee Schedule upon completion of services provided. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees **not to submit a claim** (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that the Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him/her.

Executed on_____, by_____ and Dr. Lang, D.O.
Date Patient

_____ _____

Patient signature Physician signature