

## OPT OUT OF MEDICARE PRIVATE CONTRACT

This agreement is between \_\_\_\_\_, MD, with a practice address located at 35 River Road, Cos Cob, CT, 06807 (the “Doctor”) and the patient identified below (the “Patient”) who is a Medicare Part B beneficiary and is seeking health care services that are, or may be, covered by Medicare Part B from the Doctor.

The Patient and the Doctor hereby agree as follows:

1. The Patient understands that the Doctor has “opted out” of the Medicare Part B Program. The Patient agrees that by signing this Privacy Contract, the Patient is agreeing to make payments to the Doctor according to the Doctor’s usual and customary fees.
2. The Patient accepts full responsibility for payment of the Doctor’s charge for all services furnished by the Doctor to the Patient.
3. The Patient understands that Medicare limits do not apply to the amounts that the Doctor may charge for the Doctor’s services.
4. The Patient agrees not to submit a claim to Medicare or to ask the Doctor to submit a claim to Medicare.
5. The Patient understands that Medicare payment will not be made for any items or services furnished by the Doctor that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
6. The Patient understands that the Patient has the right to obtain Medicare-covered items and services from other physicians and practitioners who have not opted out of Medicare, and that the Patient is not required to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
7. The expiration of the Doctor’s “opt out” period is approximately \_\_\_\_\_.
8. The Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
9. The Doctor is not and has never been excluded from the Medicare Program.

Accepted and Agreed  
 By PATIENT

Accepted and Agreed  
 By DOCTOR

Signed \_\_\_\_\_

Signed \_\_\_\_\_

Print: \_\_\_\_\_

Print: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\* If signed by legal representative, indicate relationship to Patient. \_\_\_\_\_