

This agreement is between **Dr. Robin Oshman**, whose principal place of business is 101 Long Lots Road; Westport, CT; 06880, and (patient) \_\_\_\_\_ who resides at \_\_\_\_\_ and is a Medicare Part B beneficiary seeking services 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, effective May 1, 2012 for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (see attached): In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the attached fee schedule. Patient also agrees, understands and expressly acknowledges the following:

**Initial:**

\_\_\_\_ Patient agrees not to submit a claim (or to request that Physician submit a claim) to 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 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 not opted-out.

\_\_\_\_ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that 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.

\_\_\_\_ Patient agrees to reimburse Physician for any costs and reasonable attorney's fees that result from violation of this Agreement by Patient or his beneficiaries.

**Executed on \_\_\_\_\_ by \_\_\_\_\_ and Dr. Robin Oshman**

**Patient signature** \_\_\_\_\_

**Physician signature** \_\_\_\_\_