



## Private Contract for Medicare Patient

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Chart #: \_\_\_\_\_

By signing this contract, I understand and agree that I will not (and will not request my oral and maxillofacial surgeon to) submit a claim to Medicare or its agents for services provided by Oral and Maxillofacial Surgical Specialists, PC, even if such services would otherwise be covered benefits.

I agree to be fully responsible through insurance (other than Medicare) or otherwise, for payment of services rendered by Oral and Maxillofacial Surgical Specialists, PC and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that Medigap plans and other secondary insurance plans may elect not to make payments for such services.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for which Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that Oral and Maxillofacial Surgical Specialists, PC have chosen to opt-out of the Medicare program and were not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective starting \_\_\_\_\_,

and it will expire on \_\_\_\_\_ (one year).

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Patient's (or Legal Guardian's) Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date