JULIA EILENBERG, MD

Medicare "Opt-Out" Contract

This agreement is entered into by and between Julia Eilenberg, M.D. (hereinafter called "Physician"), whose principal medical office is located at 6369 Mill Street Suite 212 Rhinebeck NY,

And _____
(a beneficiary enrolled in Medicare Part B, hereinafter called "Beneficiary"), who resides at

_____

Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
2. Physician agrees not to submit any claims for payment under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.
3. Physician acknowledges that (s)he will not execute this contract at a time when the Beneficiary is facing an emergency or urgent healthcare situation.
4. Physician agrees to provide the beneficiary or his/her legal representative with a copy of this document before items or services are furnished to the beneficiary under its terms.
5. Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS), upon the request of the CMS.

Obligations of Beneficiary

1. Beneficiary or his/her legal representative agrees to be fully responsible for payment of all items or services furnished by Physician and understand that no reimbursement will be provider under the Medicare program for such items or services.
2. Beneficiary or his/her legal representative acknowledges and understands that no limits under the Medicare program (including the limits under section 1848 (g) of the Social Security Act) apply to amounts that may be charged by Physician for such items or services.
3. Beneficiary or his/her legal representative agrees not to submit a claim for payment to Medicare and further agrees not to ask Physician to submit a claim for payment to Medicare.
4. Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
5. Beneficiary or his/her legal representative enters into this contract with the knowledge and understanding that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the Beneficiary 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 of Medicare.
6. Beneficiary or his/her legal representative understands that Medigap plans (under section 1882 of the Social Security Act) do NOT, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.
7. Beneficiary or his/her legal representative acknowledges that the Centers for Medicare and Medicaid Services (CMS) has the right to obtain copies of this contract upon request.

Physician's Status

Beneficiary or his/her legal representative further acknowledges his/her understanding that Physician [has/has not] been excluded from participation under the Medicare program under section 1128, 1156, 1892 or any other section of the Social Security Act.

Term and Termination

This agreement shall become effective on _____ and shall continue until the physician's opt out status comes up for renewal on _____. Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary or his/her legal representative agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract shall survive this contract.

Successors and Assigns

The parties agree that this agreement shall be fully binding on their heirs, successors, and assigns. The parties hereto, intending to be legally bound by signing this agreement below, have caused this agreement to be executed on the date written below.

_____ Name of Physician (printed)	_____ Name of Beneficiary (printed) or his/her Legal Representative
_____ Signature of Physician	_____ Signature of Beneficiary or his/her Legal Representative
_____ Date of Signature	_____ Date of Signature