



VALLEY WELLNESS CENTER

A Medical Corporation

1300 Mable Ave., Suite C, Modesto CA 95355
Phone (209) 577-2799 Fax (209) 338-5152

Medicare Opt Out Release Form

Are you a Medicare part B beneficiary? Yes No

If your answer was no, Please sign and date below

Patient Signature _____ Date _____

If you answered "YES", please continue to read, Initial and sign this agreement form.

This agreement is between Dr. Rhoades "physician", whose principal place of business is Valley Wellness Center (address in header) 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. Dr. Hunt has informed the patient that she has opted out of Medicare Program.

Patient agrees, understands and expressly acknowledges the following:

1. Patient agrees not to submit a claim (or to request that physician submit a claim) to the Medicare program with respect to services offered at Valley Wellness Center even if covered by Medicare Part B _____.
Initials
2. Patient is not currently in an emergency or urgent health care situation _____.
Initials
3. Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for services offered at Valley Wellness Center _____.
Initials
4. Patient acknowledges that Medi-Gap plans will not provide payment nor reimbursement for services offered at Valley Wellness Center because

payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement _____.

Initials

5. Patient acknowledges that he/she has a right, as 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 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 _____.

Initials

6. 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 provided at Valley Wellness Center and that no Medicare reimbursement will be provided _____.

Initials

7. 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 _____.

Initials

8. Patient acknowledges that a copy of this contract has been made available to him/her _____.

Initials

9. Patient agrees to reimburse Valley Wellness Center for any costs and reasonable attorneys' fees that result from violation of this agreement by patient or his beneficiaries _____.

Initials

Patient Signature _____ Date _____