MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES

Medicare Beneficiary Name:	
Medicare ID:	
Beneficiary Address:	
Legal Representative (if applicable)	

This agreement is made by and between GLOVER FAMILY MEDICINE ("Practice") and the individual listed above ("Patient" or "Beneficiary"). Patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Practice has informed Beneficiary or his/her legal representative that Physicians at the Practice have opted out of the Medicare program. Physicians in the Practice have not been excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 of the Social Security Act. Beneficiary or his/her legal representative agrees, understands, and expressly acknowledges the following:

Please read each line carefully and initial to indicate your agreement with the statement.

______ I want the services provided by Physician and Practice. I understand that Medicare will not be billed for these services and that I cannot appeal if Medicare is not billed.

______ I accept full responsibility for payment of Practice's charges for all services furnished by the Physician.

______ I understand that Medicare limits do not apply to what Practice may charge for items or services furnished by the Physician.

______ I agree not to submit a claim to Medicare or to ask the Practice or my Physician to submit a claim to Medicare.

______ I understand that Medicare payment will not be made for any items or services furnished by Practice or my Physician that would have otherwise

been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

______ I am entering into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and I am 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.

______ I understand that my Physician has elected for a rolling opt-out period and that there is no expected expiration date of the opt-out period.

______ I understand that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

______ I acknowledge that I am not currently in an emergency or urgent health care situation.

______ I acknowledge that I have been given a copy of this contract.

Executed on:______________________

By: ______________________________

Medicare Beneficiary or his/her legal representative

And: ______________________________

Jamie D. Glover, M.D., Glover Family Medicine