VIRTUE MEDICINE P.C.

Clinics for Mind-Body Health

Studio for Ethics & Contemplative Arts

Medicare Patient Contract
(Please initial each information block)

This agreement is between Dr. _____, whose principal place of business is 221 E. College St. Ste. 212, Iowa City, IA 52240 and:

Beneficiary: _____

Who resides at: _____

_____

Medicare ID #: XXX-XX-__ __ __ __ __

The beneficiary is a Medicare Part B participant seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The doctor has informed Beneficiary or his/her legal representative that the doctor has opted out of the Medicare program**.** The doctor is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the doctor's charge for all services furnished by the doctor.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the doctor may charge for items or services furnished by the doctor.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the doctor to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the doctor that

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

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from doctors and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other doctors or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands 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.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available.

I have had opportunity to discuss all aspects of this agreement with my health care provider. My signature below demonstrates that I have read, understand and agree to abide by the terms of this agreement for the duration of my care with my provider and during the period that she is opted out of the Medicare program.

Executed by:

_____ _____

Beneficiary or his/her legal representative **Date**

and

_____ _____

Dr._____ **Date**