Sarasota Oral & Implant Surgery

ORAL MAXILLOFACIAL SURGERY | DENTAL IMPLANTS | BOARD CERTIFIED

2130 South Tamiami Trail | Sarasota FL 34239
Phone 941-365-3388 | Fax 941-954-0521
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This agreement is between Sarasota Oral & Implant Surgery, whose principal place of business is 2130 South Tamiami Trail, Sarasota, FL 34239, and the patient_____ , who resides at _____ and who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed the Patient that the Physician has opted out of the Medicare program and is excluded from participating in Medicare Part B.

The Physician agrees to provide the following medical services to the Patient:

In exchange for the services the patient agrees to make payments to the physician. The patient also agrees, understands and expressly acknowledges the following:

_____ Patient agrees not to submit a claim (or to request that the physician submit a claim) to the Medicare program with respect to the services, even if covered by Medicare Part B.

_____ Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for services.

_____ Patient is not currently in an emergency health care situation.

_____ Patient acknowledges that Medi-gap plans will not provide payment.

_____ Patient has a right to seek care from a physician who has not opted out of the Medicare Program. The patient is not compelled to enter into this private contract.

_____ Patient agrees to be responsible to make payment in full for the services furnished by the physician and acknowledges that the physician will not submit a Medicare claim for the services and no Medicare reimbursement will be provided.

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

_____ Patient agrees to reimburse the physician for any costs and attorneys' fees that result from violation of this agreement by the patient or his/her beneficiaries.

Executed on _____

Patient Name _____ Physician Name _____

Patient Signature _____ Physician Signature _____