

DBA: ALASKA ALTERNATIVE MEDICINE CLINIC

In accordance with S1802 of the Social Security Act, as amended by S4507 of the Balanced Budget Act of 1997, a physician or practitioner may “**OPT OUT OF MEDICARE**” and enter into **PRIVATE CONTRACTS** with Medicare Part B beneficiaries.

Alaska Alternative Medicine Clinic has chosen to “opt out” of Medicare and, therefore, must enter into a private contract with you in order to provide services to you. Please review the following private contract very carefully, and initial and sign where indicated if you agree to enter into this **private contract**.

I understand that AAMC has “OPTED OUT” of Medicare. _____

I understand that **I cannot submit a claim to Medicare for services received at AAMC nor can I ask AAMC to submit a claim for payment under Medicare, even if such items and services would otherwise be covered by Medicare.** _____

As the Medicare Beneficiary, I understand that Medicare will not provide reimbursement for any items or services received at AAMC and that I am totally responsible for payment of all fees at the time services are rendered. _____

Medicare Beneficiary understands that Medigap plans do not make payment for items and services supplied by the provider under this contract, and that other supplemental insurance plans may choose not to provide benefits also. _____

Medicare Beneficiary understands that the physicians and practitioners are not limited in the amount that may be charged the beneficiary for items and services furnished by AAMC and that beneficiary is solely responsible for such payment to AAMC. _____

Medicare Beneficiary has the right to have such items and services provided by other physician/practitioners at other clinics who have not “opted out” of the Medicare program. _____

Medicare Beneficiary has received a copy of this private contract, and has chosen of his/her own free will to engage the professional services of Alaska Alternative Medicine Clinic, Sandra C. Denton, M.D., and the medical staff as a private patient, not as a Medicare Beneficiary.

Witness:

Patient’s Signature:

Date: _____

Date: _____