FLATIRON FUNCTIONAL MEDICINE
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FLATIRON
FUNCTIONAL MEDICINE

THE INSTITUTE FOR
FUNCTIONAL
MEDICINE®

Medicare "Opt-Out" Patient Contract

ALL OF THE INFORMATION HEREIN WILL BE TREATED IN ACCORDANCE WITH ALL APPLICABLE CONFIDENTIALITY LAWS AND PRACTICES AND IS INTENDED SOLELY FOR THE USE OF FLATIRON FUNCTIONAL MEDICINE.

PATIENT NAME _____ **PATIENT SS#** _____

We have opted-out of Medicare. This contract entered into by the physician/practitioner and the Medicare beneficiary declares that the above named patient understands that by signing this contract:

1. She/He gives up all Medicare coverage of, and payment for, services furnished by the "opt-out" physician or practitioner.
2. She/He AGREES NOT TO BILL MEDICARE or ask the physician or practitioner to bill Medicare.
3. She/He is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare.
4. She/He acknowledges that MEDIGAP WILL NOT PAY towards the services AND THAT OTHER SUPPLEMENTAL INSURANCE MAY NOT PAY EITHER.
5. She/He acknowledges that she/he has the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available.

This contract is in effect from this date forward unless the physician opts back into Medicare coverage.

I have carefully read and fully understand this contract.

SIGNATURE _____ **DATE** _____