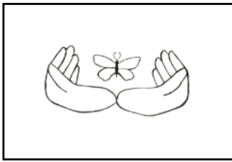

**Kate's Corner Osteopathic Care, PLC**
**Katherine A. Worden, DO, FAAO**
EIN: 88-4267597
www.katescornerosteopathic.com

# Medicare Patient Agreement (Opt-Out Status)

This agreement is between Dr. Katherine Worden and ________________________________(patient), who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Act of 1997.

Dr. Worden has informed the patient that he/she has opted out of the Medicare program effective 2021 for a period of at least two years, and that the patient is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Dr. Worden agrees to provide special medical services to the patient. In exchange for the services, the patient agrees to make payments directly to Dr. Worden pursuant to Dr. Worden's fee schedule. Patient also agrees, understands each and expressly acknowledges the following *(Please initial each line below):*

____ Patient agrees NOT to submit a claim (or to request Dr. Worden to submit a claim) to the Medicare program for her services, even if the patient is covered by Medicare Part B.

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

____ Patient acknowledges that Medigap (supplemental insurance) plans will NOT provide payment or reimbursement for the services because payment is NOT made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

____ Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from practitioners who have not opted out of Medicare, and that the client is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other practitioners who have not opted out.

____ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for medical services and acknowledges that Dr. Worden will not submit a Medicare claim for the services and that no Medicare reimbursement will be provided.

____ Patient understands that Medicare payment will not be made for any services furnished by Dr. Worden that would have been otherwise been covered by Medicare if there was no private contract and a proper Medicare claim were submitted.

____ Patient understands that testing, such as x-rays and CT or MRI scans, or durable medical equipment, such as braces or wheelchair, can be ordered by Dr. Worden AND are payable by Medicare.

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

____ Patient agrees to reimburse Dr. Worden for any costs and reasonable attorney fees that result from violation of this agreement by the patient or his/her beneficiaries.

Effective as of _________________ (Date of patient's first visit).

Patient:
Printed name___________________________________ Dr: Katherine A. Worden, DO, FAAO

Patient Signature _________________________________ Dr. Signature _______________________

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