

Complete the following form if you have Medicare:

Lisa Mainier, D.O.
Salus Integrative Medicine, PC
2545 West 26th St., Erie, PA 16506 and Pittsburgh, PA
(P) 814-923-4025 * (P) 724-740-4572

This agreement is between Lisa A. Mainier, D.O., whose principal place of business is 2545 West 26th St. Erie, PA 16506, and

Beneficiary: _____
Who resides at: _____

Medicare ID #: _____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Dr. Lisa Mainier has informed Beneficiary or his/her legal representative that she has opted out of the Medicare program effective on July 1, 2016 for a period of at least two years. Dr. Mainier 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:

Please Initial:

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

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

_____ Beneficiary or his/her legal representative agrees **not to submit a claim to Medicare or to ask the physician 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 physician 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 physicians 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* physicians 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 to him.

Client (or client's Legally Authorized Person) signature:
Printed name of Legally Authorized Person:
Relationship to Client: Date:
Dr. Lisa Mainier (physician):
Initial when you have received a copy of this agreement:

Green highlighted areas to be signed in office.