RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

Dr. Mon is excluded from Medicare.

This agreement is between Dr. Mon whose principal place of business is 8701 Shoal Creek Blvd, Suite 404, Austin, Texas 78757, and patient _____, 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 Patient that Physician has opted out of taking Medicare..

Physician agrees to provide the following medical services to Patient:

- *Medication management as needed*
- *Psychotherapy as needed*

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Physician Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

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

Patient is not currently in an emergency or urgent health care situation.

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

Patient acknowledges that Medi-Gap 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 has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient 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.

Patient agrees to be responsible to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

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

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by _____ and Dr. Thetsu Mon

Patient Signature _____ Date _____

Patient Name (Printed) _____