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Tax ID # 271577881

NPI# 1487635892 BG
NPI# 1821157363 CW
NPI# 1831561901 AW
NPI#1578106217 SE
NPI#1700397726 NP

Patient Name: _____

Provider: _____

MEDICARE / MEDICAID PROGRAM OPT-OUT CONTRACT

1. I understand that my provider has opted out of the Medicare/ Medicaid program.
2. I further understand that I am entering into a private contract with my provider.
3. According to Medicare/ Medicaid regulations, a claim cannot be filed for my visits, either by my provider or by me. Medicare/ Medicaid will impose fines for violation.
4. I also understand that all prescriptions written by an opt-out provider will not be covered under Medicaid and will have to be self-pay.

By signing below, I understand that payment in full is due at time of service in the amounts of:

90792:	$ 395.00	(New Evaluation)
99213:	$ 130.00	(Medication Management) 15 min.
99215:	$ 240.00	(Extended Medication Management) 30 min.

_____ _____
Signature Date

(If you have secondary insurance to Medicare, please ask the receptionist for a receipt. You may then file that receipt to Medicare requesting a denial, so that your secondary insurance may be billed directly from Medicare.)

Please note that Medicaid will not pay for medications written by this office, due to our opt-out status. Medicaid will only cover medications written by an in-network provider.