OSTEOPATHY CHICAGO, LTD.

Dr. Dane J. Shepherd, D.O.

Notice of Privacy Practices

THE ATTACHED NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I have received and was given the opportunity to read the Notice of Privacy Practices for the office of Dr. Dane J. Shepherd, DO.

Signature of Patient	Date of Signature
Patient's Printed Name	Date of Birth of the Patient
Signature of Parent/Legal Guardian	Date of Signature
Parent/Legal Guardian Printed Name	Relationship to Patient

Osteopathy Chicago, LTD

Dr. Dane J. Shepherd, D.O.

Patient/Physician Medicare or Medicaid Financial Agreement

I, _____(printed name) agree to be personally and financially liable for all charges, without any limits that otherwise would be imposed, for all Medicare or Medicaid covered services provided by Dr. Dane J. Shepherd, D.O., from the date of this contract until January 1st, 2025.

I,_____(initials) agree not to bill or ask my physician to bill Medicare, Medicaid Gap, or other supplemental or secondary or primary insurance for these services while I am covered by Medicare or Medicaid.

I,_____(initials) understand that Medicare or Medicaid payment will not be made for Medicare or Medicaid services that otherwise would have been paid by Medicare or Medicaid.

I,_____(initials) also understand I retain the right to receive services from Physicians and Practitioners from whom Medicare or Medicaid coverage and payment would be available.

I,_____(initials) agree I am not facing an Emergency or Urgent health situation.

Patient Signature_____ Date_____

(Medicare/Medicaid Beneficiary or Legal Representative)

I, Dr. Dane J. Shepherd, D.O., acknowledge this contract and further state that I have been excluded from Medicare and Medicaid.

Physician Signature_____ Date_____