Medicare Disclaimer

This agreement is between Dr. Reed H. Day, whose principal place of business is 2222 E. Highland Ave, Suite #320, Phoenix, Arizona, 85016, and patient _____,

Who resides at _____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. The patient has been informed that Dr. Day has opted out of the Medicare program effective on April 1, 2009 for a period of at least 2 years, and 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. Reed Day agrees to provide the following medical services to the patient:

_____

_____

_____

In exchange for the services, the patient agrees to make payment in full to Dr. Reed Day prior to the services. Patient also agrees, understands and expressly acknowledges the following: (Please initial each line.)

___ Patient agrees not to submit a claim (or request the 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 situation.

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

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

___Patient agrees prior to the service to make payment in full for the services, and acknowledges that the physician 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 items or services furnished by the physician that would have otherwise been covered my Medicare if there were no private contract and a proper Medicare claim were submitted.

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

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

PATIENT SIGNATURE _____ PRINT NAME_____

PHYSICIAN SIGNATURE _____ DATE: _____