**MEDICARE WAIVER AND PRIVATE CONTRACT**

# This agreement is between, on the one hand, Fifth Avenue Endocrinology, PLLC (including Dr. Caroline Messer/Messer Medical, P.C. and Dr. Minisha Sood/Sood Medical, P.C.), whose principal place of business is 1080 Fifth Avenue, Suite 1A, NY, NY 10128 and, on the other hand, you:

Beneficiary (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who resides at (address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

who is a Medicare Part B beneficiary seeking services covered under Medicare Part B. The physicians (Dr. Caroline Messer and/or Dr. Minisha Sood) have informed Beneficiary or his/her legal representative that **the physicians have voluntarily opted out of the Medicare program effective as of April 1, 2017 and is valid indefinitely.** Note that a physician who has opted out may still order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided she is not paid, directly or indirectly, for the furnishing of such services.

The physician agrees to provide the following medical services to Patient:

Consultations

Follow up appointments

Medication renewals

Lab orders

Thyroid ultrasounds and biopsies as needed

Basal Metabolic Rate testing

All other services and offerings

In exchange for the Services, the Patient agrees to make payments to the Physician pursuant to the Attached Fee Schedule. Fifth Avenue Endocrinology, PLLC (including Dr. Caroline Messer/Messer Medical, P.C. and Dr. Minisha Sood/Sood Medical, P.C.) shall be entitled to reimbursement from you and the undersigned (as a legal representative) of all collection costs including attorneys’ fees associated with recovering payment from you.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Please initial next to each statement below:

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 physicians 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/her.

**By your signature below, you acknowledge that you have read and understand this notice**. Please ask us to explain if you do not understand this notice and agreement. A photocopy of this document shall be as effective and valid as the original. Thank you.

Executed on date (DD/MM/YYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary or his/her legal representative (print) Beneficiary or his/her legal representative (sign)

*If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.*

and:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Caroline Messer, M.D. Minisha Sood, M.D.

Fifth Avenue Endocrinology, PLLC Fifth Avenue Endocrinology, PLLC

Messer Medical, P.C. Sood Medical, P.C.