At Your Feet Concierge Podiatry, APC

Jennifer Nicole Falk, DPM, AACFAS

Foot & Ankle Specialist

Sports Podiatry, Cosmetic Procedures, House-calls, & Telemedicine

(c) 310-310-1201 | (e) drjfalk@ayfpodiatry.com | www.ayfpodiatry.com

MEDICARE Opt-Out/Patient Agreement

This Agreement is between Jennifer N. Falk, DPM ("Podiatrist"), whose principal place of business is 1540 6th Street, Suite 120, Santa Monica, California 90401 and whose telephone number is (310) 310-1201, and patient _____ ("Patient"), who resides at _____ (address) 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.

WHEREAS, Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary.

WHEREAS, the Podiatrist has informed Patient that Podiatrist has opted out of the Medicare program effective on October 1st, 2016 for a period of at least two (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.

WHEREAS, the Podiatrist has informed Patient that all services must be paid in full at the time of service, unless otherwise negotiated, and neither the Podiatrist nor the Patient may file a claim to Medicare for reimbursement.

NOW THEREFORE, the Podiatrist agrees to provide the following medical services to Patient (the "Services"): All care related to the foot/ankle, both surgical and non-surgical, as necessary, including but not limited to foot-related pain, injuries and deformities, nail care, custom orthotics, etc.

In exchange for the Services, the Patient, or Patient's legal representative, agrees to make payments to Podiatrist pursuant to the Attached Fee Schedule. Patient, or Patient's legal representative, also agrees, understands and expressly acknowledges the following:

[Please initial each box]

_____Patient, or Patient's legal representative, agrees not to submit a claim (or to request that Podiatrist 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, or Patient's legal representative, acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to what the Podiatrist may charge for items or services furnished by her.

_____Patient, or Patient's legal representative, 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 elect not to make payments for items and services not paid for by Medicare.

_____Patient, or Patient's legal representative, acknowledges that he or she 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, or Patient's legal representative, agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Podiatrist will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

_____Patient, or Patient's legal representative, understands that Medicare payment will not be made for any items or services furnished by the Podiatrist that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

_____Patient, or Patient's legal representative, acknowledges that a copy of this Agreement has been provided to him/her.

_____Patient, or Patient's legal representative, agrees to reimburse Podiatrist for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient and/or his/her beneficiaries.

Executed on _____ (today's date) by Patient or Patient's Legal Representative and Podiatrist at _____ (city), California.

Podiatrist:

By: _____
Jennifer N. Falk, D.P.M.

Patient:	**Patient's Legal Representative:**
_____	_____
[Print Patient's Name]	[Print Legal Representative's Name]
_____	_____
[Patient's Signature]	[Legal Representative's Signature]