***Charles H. Thorne, MD,* PLLC**
*812 Park Avenue*
*New York, NY 10021*
*(212) 794-0044 P.*
*(212) 772-1326 F.*
***www.charlesthornemd.com***

# ***MEDICARE "OPT-OUT" CONTRACT***

***Patient Name:_____***

***I UNDERSTAND THAT:***

- ***Dr. Thorne has "opted out" of the Medicare program.***
- ***I accept full responsibility for payment of Dr. Thorne's fees.***
- ***I understand that the Medicare limits do not apply to Dr. Thorne's fees.***
- ***I agree not to submit, or have a legal representative submit, a claim to Medicare or ask Dr. Thorne to submit a claim to Medicare for services rendered by Dr. Thorne.***
- ***I understand that NO Medicare payment will be made for services rendered by Dr. Thorne that would have otherwise been covered if Dr. Thorne had not "opted out" of Medicare and a proper Medicare claim had been submitted.***
- ***I enter into this contract with Dr. Thorne with the knowledge that I have the right to obtain Medicare-covered items and services from other physicians and practitioners who have not opted out of Medicare. Further, I am 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.***
- ***I understand that Medigap insurance plans do not, and other supplemental insurance plans may not, make payments for items and services not paid to Dr. Thorne by Medicare.***
- ***I understand that this contract does not apply to emergency care services or urgent care services for which I may receive some reimbursement from Medicare.***

_____ _____

***Patient's Signature* (or legal representative) (*Date*)** ***Charles H. Thorne, MD,* PLLC**