Richard Polson, R.Ph., D.D.S.

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MEDICARE PRIVATE CONTRACT

By signing this contract, I understand and agree that I will not submit (nor request that Dr. Polson and/or Craniofacial Pain Associates, PA submit) a claim to Medicare or its agents for services provided by Dr. Polson and/or Craniofacial Pain Associates, PA, even if such services would otherwise be covered.

I agree to be fully responsible for payment of services rendered by Dr. Polson and/or Craniofacial Pain Associates, PA, and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by Dr. Polson and/or Craniofacial Pain Associates, PA, for the services provided.

I understand that Medigap plans do not, and other health and medical care insurance plans may elect not to, make payments for such services.

I understand that I have the right to have services provided by other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that Dr. Polson and/or Craniofacial Pain Associates, PA, are not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on ________________, and it will expire on _____________.
(date) (date)

Signature: ____
(Patient or Legal Representative)

Patient Name: ________________________________Date: ______________________

Patient Address: ____

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Richard Polson, R.Ph., D.D.S.
NPI# 1558317750