## Patient's Medicare Coverage Waiver

I acknowledge that I have been informed by Dr. _____ that he is opting-out of Medicare for the following service(s) he will be providing to

_____/_____
(Patient's name) (Medicare-number)
and that he will be charging fees higher than the ones payable by Medicare:

Service Code: _____

Date of Service: _____

I understand also that in accepting the service(s) under these conditions I waive all rights to any reimbursement from Medicare for these services.

I have been informed by the practitioner that this service(s) is available from a practitioner who would accept Medicare payments as payments in full.

I accept the service(s) referred to above under these conditions.

_____ _____
Signature of Beneficiary Date

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## Practitioner's Opting-Out Statement

I certify that I have informed the above-named beneficiary that I am opting-out as stated above. I have no reason to believe that in so doing I am restricting reasonable access to necessary medical services.

I also certify that this opting-out provision is not being invoked for emergency condition or for continuation of care commenced on an opted-in basis. Further, in the case of care provided in a hospital, I certify that I informed the patient of my opting-out in advance of the admission to the hospital.

_____ _____
Signature of Practitioner Date