

PATIENT MEMBERSHIP AGREEMENT

Medicare Beneficiary Addendum

This Agreement is between New West Medical Care, PLLC (“New West”) whose principal place of business is 14508 NE 20th Avenue, Suite 102, Vancouver, WA 98686, and patient _____ (“Patient”), who resides at _____, 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.

New West has informed Patient that New West has opted out of the Medicare program effective on _____, for a period of at least two 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.

In exchange for the Membership Services, the Patient agrees to make payments to New West pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

Initial:

_____ Patient agrees not to submit a claim (or to request that New West 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 acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.

_____ Patient 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 likewise deny reimbursement.

_____ Patient 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 agrees to be responsible, whether through insurance or otherwise, to make

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payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

_____ Patient understands that Medicare payment will not be made for any items or services furnished by the New West physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

_____ Patient acknowledges that a copy of this contract has been provided.

_____ Patient acknowledges that a copy of the Patient Handbook has been provided.

_____ Patient acknowledges that the Membership Agreement has been reviewed, understood and signed and that a copy of this agreement has been provided.

Patient – Print Name

New West Staff– Print Name

Patient – Signature

Date

New West Staff– Signature

Date