Private Contract with Medicare Beneficiary

In Compliance with 42 U.S.C. §1395a; 42 C.F.R. §405, Subpart D; 33 P.L. §4507

This agreement is between Colleen A. Blanchfield, M.D. ("physician"), whose principal place of business is 11490 Commerce Park Drive Suite 420 Reston, VA 20191 and the Medicare Part B beneficiary _____ ("beneficiary"), who resides at _____.

Physician Obligations

The physician has informed the beneficiary that the physician has opted out of the Medicare program effective on March 1, 2014 for a period of at least two years. The estimated expiration of the opt-out period is February 29, 2016 at which time the physician may renew the opt-out period in accordance with 42 U.S.C. §1395a.

The physician acknowledges that the physician has not been excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services.

The physician acknowledges that the physician must retain this contract (original signature of both parties required) for the duration of the opt-out period and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), upon request.

The physician shall provide a copy of this contract to the beneficiary, or to the beneficiary's legal representative, before items or services have been furnished to the beneficiary under the terms of the contract.

The physician acknowledges that the physician must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or beneficiary's legal representative, agrees not to submit a claim (or to request that the physician submit a claim) to the Medicare program for services rendered by the physician even if such services are otherwise covered by the Medicare program.

The beneficiary, or beneficiary's legal representative, agrees to be responsible for payment of services rendered by the physician and understands that no Medicare reimbursement will be provided for such services.

The beneficiary, or beneficiary's legal representative, acknowledges that no limitations, neither the Medicare program's fee limitations nor any other Medicare program reimbursement regulation, apply to charges for services rendered by the physician.

The beneficiary, or beneficiary's legal representative, acknowledges that MediGap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payment for services rendered by the physician because payment is not made under the Medicare program.

The beneficiary, or beneficiary's legal representative, acknowledges that the beneficiary had the right, as a Medicare beneficiary, to have such services provided by other physicians or practitioners for whom payment would be made by the Medicare program; physicians and practitioners who have not opted out of the Medicare program.

The beneficiary, or beneficiary's legal representative, acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

The beneficiary, or beneficiary's legal representative, acknowledges that a copy of this contact has been made available to him or her.

The beneficiary, or beneficiary's legal representative, agrees to reimburse the physician for any costs and reasonable attorney fees that result from violation of this Agreement by the beneficiary or beneficiary's legal representative.

I, the beneficiary or beneficiary's legal representative, have read this document containing the terms and conditions for such services provided by Colleen A. Blanchfield, M.D. ("physician") and by signing below I agree to abide by, and be obligated by, such terms and conditions. I recognize that I have the right to ask for assistance in understanding this document prior to signing it.

Beneficiary Name: _____ _____
(signature) (date)

_____
(print name)

Beneficiary's Legal Representative:
(if beneficiary is under 18 years old, indigent, or assigned a legal guardian)

_____ _____
(signature) (date)

_____
(print name)

Physician Name: _____ _____
Colleen Blanchfield, MD (date)