ORAL AND MAXILLOFACIAL
SURGERY OF THE LOWCOUNTRY

Medicare
Private Contract

By signing this contract I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agents for services provided by Oral and Maxillofacial Surgery of the Lowcountry, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Oral and Maxillofacial Surgery of the Lowcountry, 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 the oral and maxillofacial surgeon for 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 oral and maxillofacial surgeons or 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 Oral and Maxillofacial Surgery of the Lowcountry is 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)

Patient Name: _____ Date: _____
(Print)

Patient's Signature: _____

Oral and Maxillofacial Surgeon's Representative Signature: _____