Medicare: Out of Network Acknowledgement and Waiver

814 E. Jackson St. Ste A
Medford, OR 97504
(541)779-2525

In this contract, I understand that InSight Vision Therapy is a private practice that does not bill Medicare for its provided services that may or may not be billable to Medicare.

As required by law, this agreement clearly states that the doctor, Joanna Carter, OD. is provider in good standing with the Medicare program under Section 1128, 1156, or 1892 of the Social Security Act.

- I accept full responsibility for payment of charges for all services furnished.
- I understand that Medicare limits do not apply to the charge for items or services.
- I agree not to submit a claim to Medicare or to ask InSight Vision Therapy to submit a claim to Medicare.
- I understand that Medicare payment will not be made for any items or services furnished by InSight Vision Therapy that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I enter into this contract with the knowledge that they have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that they are 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.
- The expected or known effective date is August 15, 2016 and will remain in effect from this date forward. The opt-out contract with Medicare will automatically renew every 2 years.
- I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- This contract cannot be entered into by the patient during a time when the patient may require emergency care services or urgent care services.
- I acknowledge that a copy of this agreement has been made available to me, and InSight Vision Therapy will retain the original contract for the duration of the opt-out period and will supply CMS with a copy of this contract upon request.

By signing this contract, the beneficiary or the beneficiary's legal representative, agrees to pay InSight Vision Therapy according to InSight Vision Therapys fee schedule. Patient also agrees, understands, and expressly acknowledges the details of this contract.

Patient or legal representative printed name: _____

Signature:_____On this Date of:_____

InSight Vision Therapy Representative

Signature_____Date:_____