Harold Goodman,D.O., LLC

8609 Second Avenue, Suite 405B
Silver Spring, MD 20910

(301) 565 2494

PRIVATE CONTRACT WITH MEDICARE BENEFICIARY FOR SERVICES PROVIDED BY HAROLD GOODMAN, D.O.

I, _____, Medicare beneficiary, clearly understand that by signing this contract I:

1. Acknowledge that I am aware that Harold Goodman, D.O. has voluntarily excluded himself from Medicare.

2. Agree to be responsible for payment of such items or services and understand that no reimbursement will be provided for such items or services by Medicare.

3. Acknowledge that no limits that would otherwise be imposed by Medicare apply to amounts that may be charged for such items or services.

4. Agree not to submit a claim to Medicare or ask Dr. Goodman to submit a claim for any items or services provided by Harold Goodman, D.O., even if such items or services are otherwise covered by Medicare.

5. Acknowledge that, as Medicare beneficiary, I have the right to such items or services provided by other physicians or practitioners, for whom payment would be made for services covered under Medicare.

6. Acknowledge that Medicare plans do not, and other supplemental plans may elect not to make payments for such items and services because payment is not made by Medicare.

7. Acknowledge that as of this signing I am not facing an emergency or urgent health situation.

Patient Name:_____

Patient Signature:_____

Date:_____

Physician Name: Harold Goodman, D.O.

Physician Signature:_____

Date:_____