

PATIENT'S REQUEST AND CONSENT FOR NON-MEDICARE SERVICES

I, the Medicare beneficiary of the beneficiary's representative:

- Gives up all Medicare coverage of, and payment for services furnished by Dr. S. Randolph Waldman and Dr. Stephen A. Schantz;
- Agrees not to bill Medicare or ask Dr. Waldman or Dr. Schantz to bill;
- Is liable for all charges of Dr. Waldman and Dr. Schantz, without any limits that would otherwise be imposed by Medicare;
- Acknowledges that Medicare will not pay towards our services and the other supplemental insurers may not pay either;
- Acknowledges that he or she has the right to receive services and the other supplemental insurers may not pay either;
- Acknowledges that he or she has the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available.

I provide this request and consent to protect future access to private medical care based on payments using private method. I request and consent that the medical office of Waldman-Schantz Plastic Surgery provide medical services to me outside the Medicare and other governmental programs in emergency and non-emergency circumstances. I acknowledge and consent that no documentation will be provided for such services to enable reimbursement from Medicare or other governmental programs in emergency and non-emergency circumstances.

Neither I nor my heirs, executors, administrators, successors, beneficiaries or assigns will submit a claim (or request that a claim be submitted) for services provided by these private physicians. I acknowledge that such services may fall within the scope of Medicare or other governmental programs, and that I have the right to seek such services from other providers if I wish to obtain reimbursement by the government. I consent that the fees charged by these private physicians for such services may be greater or less than the charges established by Medicare programs.

I hereby acknowledge and consent that these private physicians are justified in relying upon this request and consent in providing all future services to me, whether during an emergency or not. In the event that I take any action contrary to this request and consent which causes administrative or legal expense to either of these physicians, I will provide reasonable reimbursement.

Waldman Schantz Plastic Surgery
3288 Eagle View Lane, Ste 300
Lexington, KY 40509
859.254.5665
www.WaldmanPlasticSurger.com



This is not a private contract for any item or service. The undersigned is not obligated in any matter to obtain any medical service from Dr. Waldman or Dr. Schantz and remains free to seek medical care from any other provider at any time. The form is confidential and may not be construed to allow disclosure of any information concerning this patient.

BENEFICIARY'S SIGNATURE:

DATED:

WITNESS:

DATED:

PROVIDER:

DATED:

Waldman-Schantz Plastic Surgery
3288 Eagle View Lane, Suite 300
Lexington, KY 40509
(859) 254-5665