THOMAS P SENTER, MD

MEDICARE BENEFICIARY NAME: _____

- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR ALL SERVICES FURNISHED BY THOMAS P. SENTER, M.D. **PLEASE INITIAL:_____**

- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE, AGREE NOT TO SUBMIT A CLAIM TO MEDICARE OR TO ASK THOMAS P SENTER, M.D. TO SUBMIT A CLAIM TO MEDICARE. **PLEASE INITIAL:_____**
- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE, UNDERSTAND THAT MEDICARE PAYMENT WILL NOT BE MADE FOR ANY ITEMS OR SERVICES FURNISHED BY THOMAS P. SENTER, M.D. THAT WOULD OTHERWISE HAVE BEEN COVERED BY MEDICARE IF THERE WAS NOT PRIVATE CONTRACT AND A PROPER MEDICARE CLAIM HAD BEEN SUBMITTED.

PLEASE INITIAL: _____

- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE, ENTER INTO THIS CONTRACT WITH THE KNOWLEDGE THAT I 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 I AM 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. **PLEASE INITIAL: _____**
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- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE, WILL RECEIVE OR HAVE RECEIVED A COPY (A PHOTOCOPY IS PERMISSABLE) OF THIS CONTRACT, BEFORE ITEMS OR SERVICES ARE FURNISHED TO ME UNDER THE TERMS OF THIS CONTRACT. **PLEASE INITIAL:_____**

- I, THE MEDICARE BENEFICIARY OR MY LEGAL REPRESENTATIVE, 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. **PLEASE INITIAL:_____**

- THE EXPECTED OR KNOWN EFFECTIVE DATE, AND EXPECTED OR KNOWN EXPIRATION DATE, OF THE CURRENT OPT OUT PERIOD IS 01/01/2011 TO 01/01/2013.
- THIS CONTRACT CANNOT BE ENTERED INTO BY ME, THE MEDICARE BENEFICIARY, OR BY MY LEGAL REPRESENTATIVE DURING A TIME WHEN I, THE MEDICARE BENEFICIARY, REQUIRE EMERGENCY CARE SERVICES OR URGENT CARE SERVICE. (HOWEVER, A PHYSICIAN/PRACTITIONER MAY FURNISH EMERGENCY OR URGENT CARE SERVICES TO A MEDICARE BENEFICIARY IN ACCORDANCE WITH [3044.28] OF THE MEDICARE CARRIERS MANUAL.]
- I, THOMAS P. SENTER, M.D., WILL RETAIN THE ORIGINAL CONTRACT (ORIGINAL SIGNATURES OF BOTH PARTIES REQUIRED) FOR THE DURATION OF THE OPT-OUT PERIOD.
- I, THOMAS P. SENTER, M.D., WILL SUPPLY THE CENTER FOR MEDICARE SERVICES WITH A COPY OF THIS CONTRACT UPON REQUEST.
- I, THOMAS P. SENTER, M.D., UNDERSTAND THAT THE CURRENT PRIVATE CONTRACT REMAINS IN EFFECT FOR TWO YEARS. IF I AGAIN OPT-OUT OF MEDICARE, I WILL EXPEDIENTLY COMPLETE A NEW CONTRACT FOR EACH MEDICARE BENEFICIARY AND WILL EXPEDIENTLY SUBMIT THE APPROPRIATE AFFIDAVIT(S) TO ALL LOCAL MEDICARE CARRIERS.
- I, THOMAS P. SENTER, M.D., HAVE NOT BEEN EXCLUDED FROM MEDICARE UNDER [1128] [1156] OR [1892] OF THE SOCIAL SECURITY ACT.

_____ _____

PROVIDER'S SIGNATURE **DATE**

_____ _____

PATIENT'S OR PATIENT'S LEGAL REPRESENTATIVE'S SIGNATURE **DATE**

_____ _____

WITNESS' SIGNATURE **DATE**