

University Periodontal Associates, Inc.
3100 Richmond Avenue, Suite 509, Houston, TX 77098
(713) 523-9040

MEDICARE PRIVATE CONTRACT

This Contractual agreement is between Dr. David K. Dennison/Dr. Erick E. Matteo, (Dentist) whose principal place of business is at **3100 Richmond Avenue #509, Houston Texas** and Patient _____ (Patient; a Medicare Part B beneficiary). As a dentist that has opted out of the Medicare Program. Dr. Dennison/Dr. Di Matteo has informed Patient that treatment he/she provides to any Medicare beneficiary is not subject to Medicare limits. Pursuant to Dr. Dennison/Dr. Di Matteo's "OPT Out" agreement with Medicare, Patient has been informed that Dr. Dennison/Dr. Di Matteo is prohibited from billing Medicare for services provided to Patient. By signing this contract, the Patient or the Patient legal Representative, agrees to pay dentist according to Dr. Dennison/Dr. Di Matteo's fee schedule. Patient agrees understand and expressly acknowledges the following: **(Initial)**

_____ Patient is not currently in an emergency health care situation. (Life /death situation)

_____ Patient acknowledges that neither Medicare's fee limitation nor any other Medicare reimbursement regulations apply to services provided by Dr. Dennison/Dr. Di Matteo.

_____ Patient acknowledges that Medigap plans will not provide payment for services rendered because payment will not be made under the Medicare program. Other supplement plans may also deny payment.

_____ Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from dentist who have not opted out of Medicare and that Patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other dentist who have not opted out.

_____ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for services provided by Dr. Dennison/Dr. Di Matteo and acknowledges that Dr. Dennison/Dr. Di Matteo will not submit a claim for Medicare reimbursement.

_____ Patient acknowledges that a copy of this agreement has been available to him/her. This contractual agreement shall remain in force from the date it is signed by patient until the end of the term of Dr. Dennison/Dr. Di Matteo's opt-out period.

Agreement Accepted by: _____ **Date** _____
(Patient)

Agreement Accepted by: _____ **Date** _____
(Dentist or Representative)