

**Leslie M. Brocchini, MD**  
**Wellness Integrative MedicineCosmetics**  
**19933 Greenley Road, Suite B, Sonora, CA 95370**  
**209-288-2293**

**MEDICARE OPT OUT RELEASE FORM**

This agreement is between Leslie Brocchini, MD “physician,” whose principal place of business is 19933 Greenley Road, Suite B, Sonora, CA and \_\_\_\_\_ (“Patient”), who resides at \_\_\_\_\_ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Dr. Brocchini has informed the patient that she has opted out of the Medicare program.

Patient agrees, understands and expressly acknowledges the following:

1. Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to services offered at Dr. Brocchini’s office even if covered by Medicare Part B\_\_\_\_\_
2. Patient is not currently in an emergency or urgent health care situation\_\_\_\_\_
3. Patient acknowledges that neither Medicare’s fee limitations nor any other Medicare reimbursement regulations apply to charges for services offered at Dr. Brocchini’s office\_\_\_\_\_
4. Patient acknowledges that Med-Gap plans will not provide payment or reimbursement for services offered by Dr. Brocchini’s office because payment is not made under the Medicare program and other supplemental insurance plans may likewise deny reimbursement\_\_\_\_\_
5. Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from physicians and practitioners who have NOT opted-out of Medicare\_\_\_\_\_
6. Patient agrees to be responsible, make payment in full for the services, and acknowledges that Dr. Brocchini will **not** submit a Medicare claim for the services provided at her office and that no Medicare reimbursement will be provided\_\_\_\_\_
7. Patient acknowledges that a copy of this contract has been made available to him/her\_\_\_\_\_
8. Patient agrees to reimburse Dr. Brocchini and staff for any costs and reasonable attorney’s fees that result from violation of this Agreement by Patient or his/her beneficiaries\_\_\_\_\_
9. Regarding outside lab services by **True Health Diagnostics**, patient agrees not to submit a claim to Medicare or patient may be responsible for the entire bill\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_