Princeton Neurological Surgery

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PRIVATE CONTRACT BETWEEN JOHN D. LIPANI AND MEDICARE PART B BENEFICIARY

THIS MEDICARE PRIVATE CONTRACT (the "***Agreement***") is made effective as of _____, 20____ (Effective Date) by and between

JOHN D. LIPANI, MD, PhD, FAANS, FACS (the "***Physician***") who is employed by **Princeton Neurological Surgery, P.C.** ("***PNS***") and practices at its office located at 3836 Quakerbridge Road, Suite 203, Hamilton, NJ 08619

AND

(Patient's full name) _____ , a beneficiary enrolled in Medicare Part B ("***Patient***"), who resides at

(Patient's address) _____

_____

AGREEMENT

NOW, THEREFORE, the **Physician** and **Patient** agree to be legally bound as follows:

1. Both the **Physician** and the **Patient** (or the Patient's legal representative) acknowledge with full understanding and affirm that:

    A. The **Patient** is enrolled in the Medicare Part B program and is seeking services that may be covered under the Medicare Part B program if provided by other physicians who participate in the Medicare program.

    B. The **Physician** has opted-out of the Medicare program and the **Physician** does not participate in the Medicare Part B program.

2. The **Physician** agrees to provide the following medical treatment and services, as may be medically indicated (the "***Services***"):

Neurosurgical evaluation, management, and follow-up care including both surgical, non-surgical, and radiosurgical procedures involving the brain and/or spine.

3. In exchange for the **Services**, the **Patient** agrees to make payment directly to **Princeton Neurological Surgery, P.C.** ("***PNS***") for all fees charged for the Services pursuant to **PNS's** Fee Schedule in effect at the time the **Services** are rendered. The **Patient** (or his/her legal representative) also agrees, understands and expressly acknowledges the following:

   A. The **Patient** agrees not to submit a claim (or to request that the **Physician** submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.

   B. The **Patient** understands that Medicare fee limitations do not apply to, guide, or restrict what the **Physician** may charge for the items or **Services** furnished by the **Physician** to the **Patient**.

   C. The **Patient** does not presently require emergency care services or urgent care services.

   D. The **Patient** understands 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 the Medicare program, and that the **Patient** is not compelled to enter into private contracts such as this one.

4. The **Patient** (or his/her legal representative) understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

5. The **Patient** (or his/her legal representative) has been informed that this **Agreement** shall remain in effect for the duration of the period that the **Physician** continues to opt-out of the Medicare program, unless terminated earlier by the written agreement of the **Patient** and the **Physician**. The **Physician** will retain this original **Agreement** for the duration of the opt-out period.

6. The **Patient** hereby agrees that the **Physician** may supply the Centers for Medicare and Medicaid Services with a copy of this **Agreement** if requested to do so.

7. This **Agreement** cannot be amended without the express written consent of the **Physician** and the **Patient**. Moreover, this **Agreement** shall not be amended in any event in any manner that violates 42 CFR § 405.415 or any other regulations or statutes pertaining to the requirements for private contracts under the Medicare Program.

The **Patient** (or his/her legal representative) shall indemnify, hold harmless and defend **Physician** and his respective officers, directors, employees and agents, from and against any and all claims, losses, liabilities, costs, and other expenses (including, without limitation, reasonable attorneys' fees and costs) incurred as a result of or arising directly or indirectly out of or in connection with any failure of the **Patient** (or his/her legal representative) to comply with his/her obligations under this **Agreement**.

8. The **Patient** (or his/her legal representative) certifies that he/she has been given a copy of this **Agreement**.

IN WITNESS WHEREOF, the parties hereto have executed this **Agreement** as of the date and year first above written.

PATIENT OR LEGAL GUARDIAN:

Print Name of Patient: _____

Print Name of Legal Guardian (if applicable): _____

Signature of Patient or Legal Guardian: _____

Date of Signature: _____

PHYSICIAN:

Name of Physician (printed): _____

Signature of Physician: _____

Date of Signature: _____

WITNESS:

Name of Witness (printed): _____

Signature of Witness: _____

Date of Signature: _____