Wisconsin Integrative Pain Specialists

"Restoring function and overall well-being"

Linda Bluestein, MD

4203 Schofield Ave
Suite 2
Weston WI 54476

Office: 715.600.1722
Fax: 715.869.1798
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www.WisconsinIntegrativePainSpecialists.org

Private Contract for Medical Services
(Medicare Beneficiary)

This Agreement sets forth the terms under which Wisconsin Integrative Pain Specialists, S.C., ("WIPS") and Linda Bluestein, M.D., ("Provider") will provide health care services requested by or for _____ ("Patient"). Patient is not currently in or seeking treatment from Provider for an emergency or urgent health care situation. Patient understands that he or she is a Medicare Part B beneficiary (Medicare Id. _____) seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Patient acknowledges that Provider has informed Patient that Provider has opted out of participation in the Medicare program. Provider is not and has never been excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Patient and Provider agree as follows:

Patient understands, acknowledges, and agrees that:

- Medicare payment will not be made for any items or services furnished by Provider or Provider's practice, WIPS that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
- Medicare limits do not apply to what Provider's employer,WIPS, may charge Patient for the items or services provided under this Agreement;
- Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
- Patient accepts full responsibility for payment of all charges for any and all medical services furnished to Patient by Provider; and
- Patient may not and shall not submit claim(s) to Medicare for items or services furnished to Patient under this Agreement or request that others do so.

Patient enters into this Agreement knowing that, as a Medicare beneficiary, Patient has a right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and need not enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out. Patient understands that he or she may do so notwithstanding the existence of this Agreement at any time, but agrees to inform Provider to the extent Patient would like or has decided to do so.

This Agreement will remain in effect for the duration of Provider's opt-out period, during which time WIPS will retain the original of this Agreement. Provider's current opt-out period will expire on 11/08/2019. If Provider elects to renew this status, Provider and Patient will expediently complete a new contract following Provider's submission of the affidavit required to make this election to the local Medicare Administrative Contractor.

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Either Party may terminate this Agreement at any time by providing the other with written notice of that intention.

Patient understands and agrees that the termination of this Agreement, for any reason, shall not affect:

- Patient's obligation not to seek reimbursement from Medicare for services provided under this Agreement, or
- Patient's obligation to pay for services provided while this Agreement was effective.

The rights and obligations set forth in this Agreement are fully binding on the Parties' heirs and successors.

In the event someone other than Patient executes this Agreement that person, by signing below, represents that he or she is legally responsible for Patient, and accepts the obligations and liabilities related to health care services Provider renders for Patient under this Agreement -- including, but not limited to, the obligation to pay for such services.

Patient and/or Patient's legal representative acknowledges that a copy of this Agreement has been provided before the provision of any items or services to which its terms apply.

_____ Date: _____

Signature of Patient (or Patient's Legal Representative):

Address: _____

_____

_____

Name: _____

Telephone: _____

Email: _____

Provider's Signature:  Date: _____

Provider NPI: 1578589156

Witness: _____