This agreement is between Dr. Robert Reiser ("Provider"), whose principal place of business is **1036 Sir Francis Drake Blvd, Suite 13, Kentfield, CA 94904** and patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ("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. The Provider has informed Patient that Provider has opted out of the Medicare program effective on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Provider agrees to provide the following medical services to Patient (the "Services"): Psychotherapy and psychological counseling services

In exchange for the Services, the Patient agrees to make payments to Provider pursuant to the agreed upon Fee Schedule in the Treatment Agreement. Patient also agrees, understands and expressly acknowledges the following:

1. Patient agrees not to submit a claim (or to request that Provider submit a claim) to the Medicare program with respect to the Services, 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 the Services.
4. Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
5. Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from Providers and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other Providers or practitioners who have not opted-out.
6. Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Provider will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
7. Patient understands that Medicare payment will not be made for any items or services furnished by the Provider that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
8. Patient acknowledges that a copy of this contract has been made available to him.

Executed on [date] \_\_\_\_\_\_/ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_

by [Patient name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and [Provider name] Robert Reiser, Ph.D.

[Patient signature] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Provider signature] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_